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FOLLOWUP HEARINGS ON DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

SPECIAL HEARINGS

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Alcohol, Drug Abuse, and Mental Health Administration**

DISTRICT OF COLUMBIA

Board of Parole

Department of Corrections

Executive Office of the Mayor

Office of the Budget

Public Defender Service

Superior Court of the District of Columbia

NONDEPARTMENTAL WITNESSES

Printed for the use of the Committee on Appropriations



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CONTENTS

DISTRICT OF COLUMBIA

WEDNESDAY, JULY 13, 1983

Department of Corrections.....	Page 1
--------------------------------	-----------

WEDNESDAY, JULY 20, 1983

Board of Parole	23
-----------------------	----

TUESDAY, AUGUST 2, 1983

Department of Health and Human Services:	
Alcohol, Drug Abuse, and Mental Health Administration	47
District of Columbia:	
Executive Office of the Mayor.....	67
Nondepartmental witnesses.....	77

TUESDAY, SEPTEMBER 27, 1983

Office of the Budget	219
Nondepartmental witnesses.....	225
Public Defender Service	247
Nondepartmental witnesses.....	251

TUESDAY, NOVEMBER 1, 1983

Board of Parole	257
-----------------------	-----

TUESDAY, NOVEMBER 8, 1983

Superior Court of the District of Columbia	299
Office of the Budget	324
Public Defender Service	326

TUESDAY, NOVEMBER 15, 1983

Department of Corrections.....	331
--------------------------------	-----

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

WEDNESDAY, JULY 13, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:10 p.m., in room SD-128, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Member present: Senator Specter.

Staff present: Tim Leeth, counsel, and William Bowman, counsel for the Judiciary Committee.

DISTRICT OF COLUMBIA

DEPARTMENT OF CORRECTIONS

STATEMENT OF JAMES PALMER, DIRECTOR, DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS

ACCOMPANIED BY:

THOMAS DOWNS, CITY ADMINISTRATOR
MICHAEL E. ZIELINSKI, ASSISTANT CORPORATION COUNSEL
GEORGE HOLLAND, ASSISTANT DIRECTOR FOR DETENTION SERVICES
WILLIAM GOLIGHTLY, ASSISTANT DIRECTOR FOR ADMINISTRATION
SALANDA WHITFIELD, ACTING ASSISTANT DIRECTOR FOR CORREC-
TIONAL SERVICES

OPENING STATEMENT

Senator SPECTER. Good afternoon, ladies and gentlemen. I regret the necessity to postpone this hearing until this afternoon, but hearings were scheduled on the Civil Rights Commission nominees earlier this morning, and it was necessary for me to attend that session.

This afternoon, we are going to be considering the issue of the Department of Corrections and the problems which confront that very important unit.

Earlier this year, we had hearings into the overall problems of the District of Columbia in connection with the appropriations process, and at that time a number of specific issues arose which required further attention.

Some of those related to the criminal justice system, a subject that I have long been interested in from my experience as District Attorney of the city of Philadelphia, and one of the subjects of concern to me is the

speed of the trial of cases in the court system, and then what happens to those after they are sentenced.

Those issues touch on the Department of Corrections, which has a very substantial burden in detention prior to trial, and then in sentencing after trial.

VISITS TO LORTON AND THE DETENTION CENTER

Earlier this year, on June 20, Mayor Barry and I visited the Lorton facilities. A few days later, on June 29, Mayor Barry took me on a tour of the District of Columbia correction facilities and detention center, and this hearing is a followup effort to see what can be done on that important subject.

On June 29, the day that Mayor Barry and I were there, the statistics showed that the jail had 2,429 inmates in facilities which were designed to hold 1,335 inmates, a very substantial problem of overcrowding.

This issue has come before the court, there is court supervision at both Lorton and the D.C. jail, and it is a matter which I believe we have to address our attention to.

Beyond the issue of simple detention, there is the question of what is going to happen to people after they are released from jail. There has emerged in this country a pattern of those who are released going back to lives of crime, and it is small wonder that functional illiterates without a trade or a skill go back to the criminal cycle. We are taking a look in this hearing, and otherwise, at the issue of how to deal with that problem and what realistic rehabilitative facilities might be made available.

I noted in this week's press that on the issue of a major raid to round up people suspected of crime, the Mayor had analyzed the problems of the detention facilities prior to undertaking that police law enforcement action. I think it is an obviously serious situation when the chief executive of a city like Washington, D.C., has to be concerned about the availability of detention facilities in evaluating a law enforcement action, and that is something that I know he does not like to have to do, nor does the Chief of Police, nor the correction authorities themselves. That underscores and highlights the problem.

GOOD JOB OF DISTRICT OFFICIALS

I do think it important to focus on the fact that the D.C. officials are doing a good job with the limited facilities which are involved. The Mayor is, in my judgment, doing a good job. He is very sincere and very dedicated. Director James Palmer of the D.C. Department of Corrections, I think, is doing a good job with the facilities available. The units that I visited, both at Lorton and the D.C. jail were clean and well kept. There was double bunking in the D.C. jail as a matter of necessity, and to the extent that this committee can be helpful in solving those problems, we wish to do so.

PREPARED STATEMENT

I will have my full statement made a part of the record to supplement what I have already said, and at this time we will proceed with the testimony of James Palmer. Mr. Palmer, why don't I turn this over to you and ask you to introduce those with you.

[The statement follows:]

STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

This spring we began hearings on all aspects of the District of Columbia and its budget. My intention was to obtain a general picture first, then concentrate on the problem areas at a later time. On April 27, we heard from James Palmer, the Director of the Department of Corrections, and several members of his staff. At that time, we received an overview of the situation in corrections and a 1984 budget request of slightly over \$102 million.

Today is the first of several hearings designed to focus in more detail on the District's criminal justice system. It is my sincere hope that the District, with any help that Congress can provide, will work to solve some of the very serious challenges facing our city. I have a longstanding interest in criminal justice issues and a deep commitment to making the system work well in the District. Indeed, I believe that the District of Columbia can serve as a model for other jurisdictions.

Surely there is no problem within the District's criminal justice system more pressing than the corrections problem. It is fair to say that crowding at the D.C. jail has now reached crisis proportions. The sheer numbers alone have meant that many sentenced prisoners have had no or little access to educational and vocational programs.

With these problems in mind, I visited the Lorton facilities on June 20 and the D.C. jail on June 29, with Mayor Barry and several officials from the Department of Corrections. While I found these institutions to be clean and well run, some serious deficiencies were also apparent.

On June 29, the jail, designed to hold 1,335 persons, had 2,429 inmates. In 1981, the jail averaged about 1,500 persons, and approximately 1,900 in 1982. Although D.C. law requires that those awaiting trial be kept in separate institutions from sentenced prisoners to the extent practicable, there were on that day 714 sentenced felons at the jail. All but four of the cellblocks have double cells, and there are overflow beds in lounge areas. About 1,400 are awaiting trial, some for as long as a year. The crowding problem has become so serious that Federal District Court Judge William Bryant has ordered a show cause hearing for August 9 to determine if strict rules he has set to deal with the crowding have been violated. Last week the District filed a memorandum with the court detailing its plans for dealing with the problem.

Of equal concern to me is the status of educational and vocational programs within the corrections system. I am firmly convinced that we must work to insure at least minimal literacy and vocational training before a prisoner's release or we will just see him back in the system again. I was impressed during my Lorton visit by what I saw, but I saw far too little in the way of education and job training.

Finally, it is now painfully obvious that one short-term solution to the problem is to increase capacity. I will be most interested to hear what planning has occurred, what the population forecasts are, what construction work is in progress and is planned, what the manpower needs are, and what major steps are being taken to develop realistic alternatives to incarceration.

The first witness will be the Director of the Department of Corrections, James F. Palmer. He will be accompanied by William D. Golightly, Assistant Director for Administrative Services, George E. Holland, Assistant Director for Detention Services, and Salanda Whitfield, Acting Assistant Director for Correctional Services.

Next, we will hear from Thomas Downs, City Administrator and Deputy Mayor for Operations for the District of Columbia. We hope to learn the city's plan for dealing with this crisis.

INTRODUCTION OF DISTRICT WITNESSES

Mr. PALMER. On my right is Deputy Mayor and City Administrator, Mr. Thomas Downs. To my left I have Assistant Director for Administration, Mr. William Golightly, and to my far left I have the Acting Assistant Director for Correctional Services, Mr. Salanda Whitfield. To my far right I have Michael Zielinski, Assistant Corporation Counsel, who represents us in litigation, and to his right is Mr. George Holland, the Assistant Director for Detention Services.

Senator Specter, if I could, I would like to make my opening statement a part of the record.

PREPARED STATEMENT

Senator SPECTER. Yes; that will be made part of the record.
[The statement follows:]

STATEMENT OF JAMES F. PALMER

I am highly appreciative for this opportunity to comment on the problem of overcrowding in the facilities operated by the District of Columbia Department of Corrections. The Department's institutional resources are divided into three service areas: detention, correctional, and community. I will briefly describe each service area and present information relating to administrative and judicial actions which have had an impact on the population configuration.

The Detention Facility is the institution of admittance and discharge for all persons who are arrested and committed to the Department of Corrections. The facility opened in March 1976. Its original design provided a single-cell capacity for 1,355 prisoners. This capacity figure permits an optimum security status and provides ample space for a meaningful variety of prisoner services. For the past 5 months, however, the population has averaged approximately 2,300. This status is now pending before the U.S. District Court in the case of *Campbell, et al. vs McGruder, et al.*, Civil Action No. 1462-71. This class action civil litigation was initiated by prisoners in 1971, who were then housed in the formerly named District of Columbia Asylum and Jail. That jail was an archaic physical plant that proved to be inconsistent with the reasonable needs of prisoners and the community's sense of fair and humane treatment. Consequently, at the direction of the Honorable Marion Barry the old jail was razed and is now a matter of historical information. Most of the issues raised in the *Campbell* suit have been resolved, with the exception of the crowded conditions and a technical matter involving the administration of prison discipline.

The Honorable William B. Bryant, U.S. District Court Judge, on December 16, 1982, responded to the escalating prison population by ordering that the District of Columbia submit a plan to relieve the crowded condition. The comprehensive plan submitted by the District of Columbia in February 1983 will provide for approximately 850 new spaces in the form of expanded and renovated facilities on the Lorton Reservation. These spaces will ease the crowding at the Detention Facility, which now houses approximately 700 felon and misdemeanor prisoners who are eligible for sentencing facility placement. A copy of the plan has been provided for the committee's review.

I am concerned at this point that the plan, while being a substantial commitment to provide constitutional penal conditions in this jurisdiction, falls below projected incarceration trends. If present trends continue, the Department estimates an obligation to house 5,960 prisoners by 1987 and 6,060 by 1990. The latter figure would involve a space shortfall of approximately 800.

Notwithstanding the projected increases, the District of Columbia is taking decisive action to address the problem. The District's response, as established by the Mayor, is to decrease the high growth rates in incarcerated population in part by creating new programs and expanding existing programs directed at placement of appropriate individuals in alternative noncustodial settings. This policy is set forth in the Mayor's 1983 state of the District address, wherein it is noted:

"Population projections for the District's Department of Corrections suggest continued growth in the incarcerated population for the next several years. Ways of coping with jail overcrowding include expanding alternatives to incarceration and increasing prison capacity. Cost estimates for increasing prison capacity to handle the current and projected population range as high as \$500 million. Therefore, alternatives to incarceration for nonviolent offenders must be expanded, including an emphasis on crime prevention and community-based rehabilitation programs."

In keeping with the Mayor's policy, the Community Services area of the Department has stepped up its operations. This organization is responsible for all prisoners housed in Department operated or contract halfway houses. There are currently 272 total prisoner spaces in all eight halfway houses. The spaces are 95 percent occupied at all times. The Department does plan to expand the capacities in due course.

I would mention at this point the current status of correctional services. This service area consists of six institutions located on a 3,000-acre Federal land tract in Lorton, Va. The institutions have a total current housing capacity of approximately 2,951. This figure represents judicial ceilings imposed on three of the institutions and administrative determinations in the remaining three. The three institutions with court mandated ceilings are at full capacity. Two of the remaining administrative approved institutions are above capacity. The remaining institution is the Minimum Security Facility where rigid professional classification practice regulates prisoner placement. I am prepared to offer testimony respecting each facility if called upon by this committee.

The problem of crowded facilities has been intensely examined by the Mayor's Commission on Crime and Justice which is charged with the duty of developing and implementing specific measures to address all aspects of the criminal justice system. The Commission was created in January 1982 by the Mayor, who chairs and attends all Commission meetings. Its approximately 100 members include the U.S. Attorney for the District of Columbia, the Chief Judge of the Superior Court of the District of Columbia, the heads of all major criminal justice agencies, and many citizens interested in criminal justice planning.

The latest report of the Commission sets forth numerous proposals and programs which address not only the effort to decrease the rate of crime, and hence the number of potential incarcerated, but also to reduce the number of individuals who are incarcerated as a result of involvement with the criminal justice system. A copy of the Commission's report is attached hereto.

The Department considers prison space a prohibitively high cost commodity and continues to urge that it be utilized for individuals who pose a clear danger to the community. The District of Columbia commits approximately \$15,000 per year to the support and custody of each confined prisoner. This demand on the public treasury should be reduced. The Department of Corrections is taking a vanguard position to advocate alternatives to incarceration as a means of alleviating the present crowded conditions. Its policies also demand that all facilities be safe and secure.

Permit me to extend an invitation to the members of this committee to tour our several facilities. I would consider such a visit a privilege and personally make the appropriate arrangements.

Thank you.

PRaising THE VISIT OF SENATOR SPECTER

Mr. PALMER. Again, I would like to take this opportunity to explain to you how delighted I am. I had an occasion to go into the community after I had a visit from you. I am a native Washingtonian; I have been here 53 years. I have never known, nor have I been able to find where a U.S. Senator took the time to visit one of the facilities which I am presently the head of. I was greatly impressed by that effort.

The citizens whom I have had an opportunity to address since that, as well as the residents, were very, very much impressed with the fact that you would visit the institutions. These are the types of things that make me feel as an administrator that while I have a tremendous amount of problems, it is always good to know people like yourself are willing to listen, to come, and to actually take a chance to look.

I can assure that the inmates that I have had an opportunity to visit with and talk with, were very appreciative of that, and they are looking forward to some good things to come out of that visit.

Accordingly, I spoke with one of your assistants, and I conveyed this to him. They were very much concerned that a U.S. Senator would take the time to come out, visit, and help an institution in the District of Columbia. I got those comments from Georgetown all the way to the Southeast, to Mississippi Avenue, and that stretches a wide range of persons in the District of Columbia.

Senator SPECTER. Thank you for those comments. I very much appreciate it, and we will take it from here.

Mr. PALMER. All right.

MOVING PRISONERS FROM THE DETENTION CENTER TO LORTON

Senator SPECTER. We will try to do something about it.

Mr. PALMER. I will let Mr. Downs go first.

Well, first, Senator, in response to a number of questions you have sent to us, we have submitted our written views on a number of those. There are also a number of areas that we probably were not able to touch on because the questions did not cover them.

However, we have made some inroads into some of the areas since you have visited the institutions. Last Saturday, for an example, we removed approximately 170 persons from the detention facility to bring to almost full capacity our capabilities at the Lorton complex.

However, as you can see, even with the good intentions that we have put forth, because of the continual increase in our daily intake, we are now back to 2,347, and we have 2 days to go before Friday.

So it is a good possibility that by the close of business Friday, I will be almost in the same position that I was in last Friday, if not in a worse position.

So you can see simply by 1 week of how quickly the population increases at the D.C. jail with us removing 170 people. That's a lot of people.

INADEQUATE COORDINATION OF RECENT RAID

Senator SPECTER. If you have a couple of raids, you can increase it immediately.

Mr. Palmer, to what extent were the newspaper accounts accurate on the consideration, if you know, on the raids, whether the raids should be held, depending upon the availability of space in the jail?

Mr. PALMER. I'm not prepared to answer that question.

Mr. Downs. Senator, I would feel probably a little freer than Mr. Palmer to answer that. I would be the first to admit that there was probably an inadequate amount of coordination between the Metropolitan Police Department and the Department of Corrections. We had a meeting on the issue Monday morning in my office. We are working out a written protocol between the police department and the Director of Corrections about coordination on those kinds of activities far enough in advance to allow corrections, if necessary, to draw down a part of the jail's capacity to make room for those kinds of activities, and that requires some degree of advance notice.

Senator SPECTER. That's a tremendous problem. I find no fault with that analysis. I think you have to consider what space you have. Law enforcement is a selective matter. The police and the district attorney and other law enforcement officials cannot prosecute all the crimes there are because of limitations of assistant district attorneys and courtrooms and correctional space. So I understand that consideration. I just think it is unfortunate that you have to have that limitation.

You also have a problem of security. When you want to conduct a raid, you cannot notify very many people about it. With the best of intentions those bits of information leak out. It is a highly classified venture.

Mr. DOWNS. The information has to be tightly held, but that circle can include the command staff in the Corrections Department to allow for some flexibility in absorbing additional prisoners. That particular operation had been in planning, I think, for at least 3 months. The final decision that the Mayor made about proceeding with it, reflected the Mayor's priorities. That we have to, if necessary, make some significant impact on the drug traffic in the District. This was one of the ways of doing it, and we will make the room available. We will improve the way we make those decisions over the next several months.

Senator SPECTER. If you have to release some people from jail to make room for the next raid, you may well find some of those just released included in the new batch.

Mr. PALMER. That could very well happen, sir.

Senator SPECTER. Proceed, please.

RELIEVING OVERCROWDING AT D.C. JAIL

Mr. PALMER. With the decrease of the 170, we moved what I felt was a step closer to complying with Judge Bryant's order. In the interim, also, Senator Specter, I have met with a number of high-ranking officials within the Mayor's cabinet, and I have received a tremendous amount of support and assistance in trying to bring about a more palatable way of reducing the number of persons at the D.C. jail.

I have spoken with Mr. Downs, who has made announcements through Mr. Touchstone, Director of the Department of General Services and the Public Works Division to allow us to take out approximately 128 persons who have been approved for parole so that we might be able to release them.

This 128 represents persons who have been before our Parole Board, and have met all the criteria except two: One, they require them to have employment prior to their release, and two, a residency. Well, by getting them employed, I think they will be employed probably at the DS-1, they will work in public works, and they will have employment. Now, this is set to go into effect approximately the 30th of July. So that means I will be able to release 128 persons who will be on parole.

PAROLING 128 INMATES

Senator SPECTER. Now, where will those 128 persons go?

Mr. PALMER. Those persons will go back into the community, but they will be employed. What we are doing right now is, Assistant Director for Community Services, Mrs. Taylor, is working with the Department of Employment Services, and they are actually having the residents do the 171's so that we can process them for this type of employment.

Senator SPECTER. So you will be able to release 128 people on July 29?

Mr. PALMER. By July 30 we hope to put them back out into the community. That is what we are shooting for.

Senator SPECTER. What kind of jobs will they have?

Mr. DOWNS. Senator, as you know, or perhaps don't know, part of the administrative problem for placing someone on parole is that they have developed a residency plan, and an employment plan. In the current job market it has been impossible in some cases to develop employment plans for some of these people coming out. As a result of having no employment plan, they are still sitting at Lorton.

We looked tentatively at some public works money that was intended to be doing improvements on public facilities, roadways, and building improvements to convert it to—rather than going with an outside contractor to do some of that work—a number of lowest-wage-grade labor positions. They would be doing work like cutting grass, painting buildings, and doing some custodial work.

MONEY FOR JOBS PROGRAM

Senator SPECTER. Has any money come to the District of Columbia from the jobs program which we passed earlier this year?

Mr. DOWNS. Not that I know of. The only money that we have not been able to utilize was some U.S. Parks, Department of the Interior money. I think we had applied for about \$400,000 to do improvements on community centers, and we were denied any of those funds. They said that based on our track record, in which a number of projects were still backlogged, they were denying our application. I think those are the only funds that we have not been able to access so far.

Senator SPECTER. I ask because we have passed legislation which would provide \$4.6 billion nationally, and there should be a fair sum of money coming to the District of Columbia which might be used for some of these public service kinds of jobs.

Mr. DOWNS. A portion of those funds are being transferred into—

Senator SPECTER. Would you take a look at that and get me a response to that, see how much of that money the District expects to receive? Because from what I understand on other allocations, some of that money goes to municipalities and might be used along these lines.

It might even provide a line of consideration for use of some moneys under the jobs program. We wouldn't want to give preferential treatment to any group, because it wouldn't be fair to deprive someone who was not in jail of a job opportunity, but to the extent any of these funds are available in that line, I would be interested to know.

Mr. DOWNS. Certainly.
[The information follows:]

JOBS BILL FUNDS

The District of Columbia anticipates receiving \$27 million in jobs bill funds. Some of these funds will be used to serve this population especially with respect to labor intensive projects in the public works area which includes the Department of Transportation, Department of General Services, and the Department of Environmental Services.

Mr. PALMER. If that takes place, Senator, I will immediately have 128 bed spaces. I will then turn around and remove 128 from the detention facility, on the same date.

Therefore, that should take it down, again, to about 2,100. Ideally, I am trying my best to—

Senator SPECTER. Has the judge set a number you have to be down to?

Mr. PALMER. No, sir, he has not.

Senator SPECTER. Should you be down to 1,335?

Mr. PALMER. The capacity of the jail is 1,355. Senator Specter, right at the present time, I feel that the question is at issue. We are currently facing a possible contempt citation based on the fact that we are double celling pretrial detainees.

DOUBLE CELLING PRETRIAL DETAINEES

Senator SPECTER. You are double celling pretrial detainees?

Mr. PALMER. Yes, sir.

Senator SPECTER. Is that against the law?

Mr. PALMER. According to the court order, the judge has said that we shall not double cell for more than 30 days, and then we cannot double cell them any more. There are a number of administrative nightmares in this situation, if I might explain.

The judge has said that we should keep the persons out of the cellblock for 12 hours, and he has come back and made that decision. I have been reared in the judiciary, and I do not feel that I am a person who is going to go against what the judiciary rules. Therefore, my efforts right at this very moment are to comply with Judge Bryant's order. He has made his ruling, and I intend to follow that.

CAPACITY AT D.C. JAIL

Senator SPECTER. Mr. Palmer, let's go to the point about what is appropriate and what is realistic. You have space for 1,355 persons?

Mr. PALMER. Yes, sir.

Senator SPECTER. Ideally, it should be limited to 1,355.

Mr. PALMER. 1,355.

Senator SPECTER. In your professional judgment, is it acceptable to have more than that number?

Mr. PALMER. Yes, sir, I think that it is possible to operate a facility, a safe, secure facility, and comply with Judge Bryant at the same time.

Senator SPECTER. What would you say the maximum number is you should have in terms of not being excessively overcrowded for want of a better description?

Mr. PALMER. At an institution like the detention facility, I would say that the top figure over there, when you get to 2,000, you are getting up there.

Senator SPECTER. 2,000?

Mr. PALMER. Yes, on a temporary basis. It seems to me, Senator Specter, that we should always consider the fact that we have the flexibility to go up, but we should have a built-in mechanism that this is an emergency situation. Then we would bring it down, and not let it linger at a high figure.

Senator SPECTER. You think 2,000 would be an emergency situation, and that really is the maximum amount that you really ought to go to?

Mr. PALMER. Well, the maximum amount that you could go to in the facility, you could double cell. Now, the question is, what problems do you—

Senator SPECTER. How many would that give you?

Mr. PALMER. That would give you over 2,700 if you double celled all of the inmates.

AVAILABLE SPACE AT ST. ELIZABETHS

Senator SPECTER. My staff has been looking at other facilities to see what might be available. Let me just share some thinking with you. We have determined that there are some spots available at St. Elizabeths Hospital. Are you familiar with those facilities?

Mr. PALMER. I am familiar with them, but I am not familiar with them to the extent that there is anything I could do as the Director of the Department of Corrections. They are really not in our control.

Senator SPECTER. I realize that, but the information provided to me is that there are 200 beds there which might be appropriate for minimal security.

Mr. PALMER. Yes, sir.

Senator SPECTER. The question is, what would it cost to put them into condition to use, what would it cost to operate them, and then if it looks promising, we would want to explore what would the mechanism be to bring them under the jurisdiction of the city, a lease arrangement for perhaps \$1 a year, just something nominal, or how we might arrange it?

How helpful would it be for you to have 200 additional beds under a minimum security arrangement?

Mr. PALMER. I would fill them right away.

Senator SPECTER. Do you have a significant number of inmates who could properly be put into a minimal security arrangement?

Mr. PALMER. I would say that we do, Senator.

Senator SPECTER. While I know you haven't made a person-by-person analysis, what would say the figure would be out of the 2,400 that you have at the present time who would appropriately fit into a minimum security arrangement?

Mr. PALMER. Well, I would like to take into consideration the Lorton facility, because the persons at the jail who should not be there, should be at Lorton. If it is all right with you, I would like to put them in that category, and then I could select from that group. The persons who do

not belong at the detention center are sentenced prisoners, for misdemeanors——

Senator SPECTER. There are 700 of those?

Mr. PALMER. Yes; so, if I could put all those together, Senator Specter, I could draw a group from the whole that I feel, as the Director of the Department of Corrections, would be safe to go back into this type of situation with proper classification, and we could get the 200 and put them in.

We have people, Senator Specter, who are 5, 10, 15 days away from being released. We have people who really do not want to be on parole, because they feel that their time is up and they would rather just finish serving the 30 days or whatever they have left.

These people have been proven products, that they do not walk away, and that they do not try to escape. So with our screening process, we could release these people, who are about ready to go back into the community anyway, and I would get 200 bed spaces, I could then take 200 people, plus the 128, and have 328 people to release. So, I would be below my 2,000 right now. Of course, that would be ideal.

IDEAS FOR REDUCING INMATE POPULATION

Senator SPECTER. What other ideas do you have, Mr. Palmer, if any, for reducing the inmate population?

Mr. PALMER. On October 1, we are going to have under our control the Rehabilitation Center for Alcoholics, which we will refer to from now on as Occoquan II. Once we get Occoquan II in our control, we are going to do some minor repairs and refurbish it, and we will have that done by November 1. I intend to put 100 people in it then. We have let a contract through Mr. Touchstone of Public Works to fix the entire complex down there, and put in some access roads, which should be through by November 1.

Senator SPECTER. You are talking about the additional 100 beds for Lorton, now?

Mr. PALMER. Yes, sir. We plan to get RCA, and we are going to convert it. If we get it on October 1, I am going to set it up by November 1 so we can move 100 persons into it. If we can move that 100 inmates in November, while performing the other work that we plan to do down there, and phase it in——

EXPANSION OF PHYSICAL FACILITIES

Senator SPECTER. Are there any other plans for expansion of any physical facilities beyond that which you have already testified about?

Mr. PALMER. Yes; there is one other. We are going to take the present training center, the site where the training center is located for correctional officers, and convert that into modular structures so——

Senator SPECTER. Is that at Lorton?

Mr. PALMER. That's at Lorton. Then we can take the minimum security which we are going to fence in, and move the persons from there over to the present training facility. That will give us another 300 spaces at that facility.

Those are our plans and our hopes. That is what I have committed myself to at the present time, because I have control of Lorton.

Senator SPECTER. So you are looking to an expansion of some 400 units at Lorton?

Mr. PALMER. I hope to expand in the neighborhood of from 800 to 900 units at the Lorton complex.

Senator SPECTER. How long a period of time will that take?

Mr. PALMER. Well, by April 1984, we should be finished working with the Rehabilitation Center for Alcoholics. If I could start right at this moment, in 1 year with modular equipment, I could have the additional 400 spaces ready at Lorton on the training site.

CURRENT CAPACITY OF LORTON

Senator SPECTER. What is the total capacity of Lorton at the present time?

Mr. PALMER. The total capacity is 2,951. However, with the addition to the youth center that we have completed, we can go up to roughly 3,000.

Senator SPECTER. 3,000 capacity at Lorton?

Mr. PALMER. Yes, sir, and you know the reason for that. We could go a little higher, Senator. There are three facilities that are under court orders, you know, where I have a situation that I cannot go any further.

Realistically, and I want to be totally honest with you, I can go into some of the other institutions and move ahead a little bit with them, and eventually I could wind up with the same problem. So what I have tried to do is to keep things within reason.

ANALYSIS OF RAISING BAIL

Senator SPECTER. Mr. Palmer, are there any activities undertaken for a reevaluation of people who were there with the view to releasing more of them? For example, the people who are there awaiting trial, in the District jail, has there been any analysis as to the amount of bail they are held under, whether they must be under continued detention?

Mr. PALMER. Yes, sir. I had a meeting in Mr. Downs' office where he brought in other members of the criminal justice system, and that issue has been addressed, and is being currently addressed.

Mr. Zielinski can answer that one better than I can.

Senator SPECTER. Mr. Zielinski?

Mr. ZIELINSKI. Senator Specter, I am not personally involved in that process, but I know one of the things we submitted to Judge Bryant was a request to—a submission by the Mayor, at least—the chief judge of the superior court, and in conjunction with the U.S. attorney's office, to examine the possibility of making a more formal bond review hearing process.

I know there was a meeting yesterday between the Mayor, the U.S. attorney for the District of Columbia, and the chief judge of the superior court. I believe that was one of the topics that was discussed.

Senator SPECTER. The essence of it is to see if some reevaluation might lead to fewer people being detained on bail?

Mr. ZIELINSKI. The process that does presently exist in the superior court whereby the bail people notify the judges, the defense counsel, and the prosecutor, I believe, when a person has been held for 10 days unable to make bond, and the question is that there doesn't seem to be a followup process to that. One would assume that the defense attorney would make a bond review motion at that time, but there isn't any followup to see that that occurs, and we believe, as we stated in our paper to Judge Bryant, that that type of process should have some followup added to it, and that the consideration of the present conditions at the jail should be a factor that the judges who are going to review bonds should know about.

Senator SPECTER. Are there any other analyses? They are on bail. Then you have the sentenced group, and the issue is whether any of them is appropriate for release or for parole?

[The information follows:]

PRETRIAL DETENTION POPULATION AND BAIL REVIEW

Question. Is the Department of Corrections reexamining detainees that are being held in pretrial status? How many detainees do you have? How many of that number can be released if bail is reduced?

Answer. According to the Department's Automatic Data Processing Unit there were 2,488 detainees in the Central Detention Facility on July 7, 1983. Of the 2,488 detainees, 1,007 were unsentenced (or pretrial); 1,197 were sentenced; and 284 were parole violators. Approximately 80 percent or 227 of the 284 parole violators were pretrial (that is, new charges). Generally, 55 percent of the Central Detention Facility's population can be classified as pretrial or unsentenced.

According to title 23, section 1321 (which provides the authority for the Bail Reform Act), all pretrial incarcerated persons are to be given a bail hearing within 24 hours of their arrests. There is a provision for a 5-day hold on granting bail for violators who present serious security problems. This category constitutes a small number of all pretrial detainees (approximately 10 percent).

Defense counsel must make a motion to reduce bond amount, or pretrial release conditions in order to obtain a modification in the type of release conditions set. The Department of Corrections' major role in assisting pretrial detainees in the bail process is through the functions of the classification and parole officer.

The classification and parole officer at the detention center monitors all new admissions to detention and assists pretrial detainees in obtaining pretrial release. They facilitate detainees in the bond review process by advising them of the need for the acquisition of legal counsel to assist them in appealing bond release decisions. The Department cooperates with various bail release agencies (especially the D.C. Pretrial Services Agency), providing them with information on the status of the pretrial detained population.

The D.C. Pretrial Services Agency (PSA) has the legislative responsibility to notify the court of persons who are unable to post money bonds within a 48-hour period. However, funds have never been allocated to accomplish this task. PSA conducts bond reviews, if requested by defense counsel or judicial officers. With respect to bail studies the agency is more reactive than proactive, since funds for review have not been appropriated for the necessary interviewing and subsequent analysis associated with further studying the bail process.

The D.C. superior court information on bonds set as of July 12, 1983 indicate that there were 1,459 surety bonds, of which 158 were less than \$500 and 591 were between \$500 and \$1,000. A total of 191 percentage bonds were set during this time period, of which 31 were less than \$500 and 121 were between \$500 and \$1,000. There were 1,089 pretrial detained cases. The type of releases for the opened cases that were initiated in 1983 are as follows: Cash or surety, 88; cash, 18; surety, 654; percentage bond, 58; and holds, 271.

Of the pretrial detainees incarcerated housed in the Detention Facility in July 1983, 391 were for failure to meet bonds set in the amount of \$1,000 or less (293 cases were less than \$500). Generally, 70 percent of the annual pretrial population is released without any monetary bonds.

AUTHORITY TO RECALL FORMER BOARD MEMBERS

Mr. PALMER. The idea of releasing persons on parole, we have also gotten into that issue. Again, I went to Mr. Downs. I have received, and I concur with it—

Senator SPECTER. I am sorry. I didn't hear that.

Mr. PALMER. I have received and I concur with the piece of legislation that is pending where the Mayor would have the authority to recall former board members so that we can accelerate some of the Parole Board hearings.

Senator SPECTER. You are backed up on the Parole Board hearings?

Mr. PALMER. Senator Specter, the actual work that goes into a parole hearing comes out of my shop. I have to have our classification and parole officers do all of the writeups and everything for all of these persons prior to them going before the Parole Board. We have to make the presentation.

Now, the Parole Board will hear more parolees. We have approximately 538 persons incarcerated who are eligible for parole.

I brought all of this to the attention of the City Administrator in order for us to do everything possible at this time. I am not saying that all these people are going to make parole. I am simply trying to get them before the Parole Board so that they may be granted parole. We are going to try to do the same type of thing with this 128 that I found and identified within the institutions.

TIME FOR PROCESSING PAROLEE

Senator SPECTER. What is the time for processing a parolee?

Mr. PALMER. Well, the problem—

Senator SPECTER. Would additional funds help you? Suppose you had a sum of money which could be applied to the parole process. What could you do?

Mr. PALMER. It would speed it up, tremendously so.

Senator SPECTER. How much money would you need, and what would it do?

Mr. PALMER. The money would do this, Senator Specter. It will allow the Corrections Department to write up the case studies and to forward them to the Parole Board so that they can schedule their hearings. Then we would get more people before the Parole Board with the case writeup.

FUNDS NEEDED FOR PROCESSING PAROLEES

Senator SPECTER. Would you give me a response, perhaps in the next day or two, or perhaps you can give me an estimate now. How much do you need to get that going? You have 500 people eligible for parole who are not being processed.

Mr. PALMER. We would need in the neighborhood of approximately \$150,000.

Senator SPECTER. What would you do with the money?

Mr. PALMER. I would go out and hire staff to do the writeups, the typing, and so forth, interview the people, forward them over to the Parole Board, hope that a number of them make parole, and release them, get them out of the institution.

Senator SPECTER. That is a call for a vote, which is going to make further hearings complicated.

Mr. Downs is on the list as a witness.

Mr. DOWNS. Yes, sir.

PIECEMEALING CRIMINAL JUSTICE PROBLEMS

Senator SPECTER. Do you have anything to add, Mr. Downs, to what we have already heard?

Mr. DOWNS. In the interest of your time, Senator, I would only reiterate that we know we have a serious problem in the District and that the Mayor has made a commitment. We have, in effect, for a number of years piecemealed the problem by trying to attack various small pieces of the process.

As the Mayor said during the tour, we have a problem with the entire criminal justice system, and the Mayor has made a commitment. As Judge Bryant pointed out in his hearing, the Mayor is the logical focal point for trying to address the issues in the criminal justice system, recognizing that there is the U.S. attorney involved, a number of judges, and the corrections system as well.

Senator SPECTER. This is what I would like to do. We have an obligation to have a determination for the full Appropriations Committee for the District of Columbia next Wednesday to try to move these appropriations through, and I have to have what is called a markup in advance of that date, and we are trying to do it yet this week. We have some flexibility to go into next week.

We are trying to make an analysis, but there are a number of key spots which have been identified here, and I would like to have your help on them. If you take the issue of bail, you have roughly about 1,500 people in detention awaiting trial, maybe 1,600. I don't have my finger on the exact number. You have about 2,300 people in the D.C. jail today?

Mr. PALMER. Yes, sir.

Senator SPECTER. And 700 of those people have been sentenced. So you have about 1,600 people who are in jail because they haven't raised bail. I would like to see an analysis as to what might be doable on refining that group.

If you need more resources, funds, I would like to know. It looks to me as if you are stymied by a lack of resources here, there, and everywhere. You don't know where to rob from Peter to pay Paul, et cetera. But from what I have seen, there can be a reanalysis of those detained. I would like to know what you might do, what you would need to have an analysis of those 1,600 in detention for lack of raising bail.

Then at the other end you have 500, roughly, that you have already described who are eligible for parole.

Mr. PALMER. 538.

RESOURCES NEEDED TO INCREASE PAROLE PROCESS

Senator SPECTER. All right, 538. I would like to know where you would use the \$150,000 to process those people. I would like your best estimate as to how many of those people ought to be on parole, certainly not all of them.

Mr. PALMER. No, sir.

Senator SPECTER. But if you could process them, what you think your experience shows based on the number of successful applications, based on the number you take a look at. I would like to have a figure on that.

Mr. PALMER. All right.

May I add one thing, Senator?

Senator SPECTER. Let me take the other categories which I am trying to get responses to, because our staff is going to follow up with you.

Mr. PALMER. Yes, sir.

IMPACT OF SEVEN ADDITIONAL JUDGES ON PRETRIAL DETENTION

Senator SPECTER. Another aspect of it is, what would the help be to you if we were to get the additional seven judges that have been talked about so much. Judge Moultrie talked about the need for 51 judges, and only 44 are there, and the support personnel for the assistant U.S. attorney.

How would that simplify your lives in terms of how many would that take out of pretrial detention, and how many would it put in post-trial conviction? I would like to get an idea of that, get some idea myself of what we are talking about on the flow of your people.

Mr. PALMER. Yes, sir.

[The information follows:]

IMPACT OF SEVEN NEW JUDGES

Question. What would be the impact of seven (7) new judges on pretrial detainees as well as the sentenced population?

Answer. The potential impact of seven additional judges on the pretrial and sentenced population could lead to changes in both populations. Initially, there should be a reduction in the time lapse between arrest and final disposition, which would probably cause a decline in the pretrial detainee population and an increase in the sentenced incarcerated population. A similar effect was noted after implementation of the court delay project in 1980, which was intended to expedite case processing and reduce the backlog of misdemeanor cases then pending in superior court. As a result of this action, misdemeanor guilty dispositions increased by 44 percent in relation to 1979 and had a substantial impact on the detention population.

During calendar year 1982, approximately 60 percent of the new commitments to detention were in pretrial status. These were known to have served an average of 78 days in the detention facility, which had an average daily population in that year of about 2,100. If the addition of seven new judges had the cumulative effect of reducing average time served for pretrial detainees to 60 days, it would have caused a reduction of nearly 400 persons in that segment of the detention population. Since about 25 percent of all case dispositions in superior court receive sentences to confinement, it is

reasonable to expect that at least 100 of these cases would have been added to the sentenced incarcerated population. Therefore, the net impact on the Department's population would be a reduction of about 300 persons. These are rough estimates which do not take into account the potential impact of new legislation relating to the mandatory minimum sentencing law, restrictions on pretrial release options, and other unforeseen developments.

NEED ADDITIONAL PAROLE OFFICERS

Senator SPECTER. Go ahead, Mr. Palmer.

Mr. PALMER. The problem that I did not address is that, while I could process them out, in all honesty, I would need additional parole officers to supervise these people, so that would run me about \$180,000. We are talking about, roughly, \$300,000 to do this, because once they are paroled, I would have to have someone to supervise them.

Senator SPECTER. How many do you figure you could parole out of the 530?

Mr. PALMER. Well, let's assume if things turn out—and I always try to look on the positive side—let's say 300 persons were able to be processed, which is a high figure—

SUPERVISION OF PAROLE OFFICERS

Senator SPECTER. How many people can a parole officer supervise?

Mr. PALMER. About 50 or 60. That would be as many as he could reasonably handle. So if we got five parole officers, they could roughly handle the 300.

COST OF ADDITIONAL PAROLE OFFICERS

Senator SPECTER. You need \$180,000 for five parole officers?

Mr. PALMER. Senator Specter, we would need it, because there are a lot of fringe benefits built in, besides the fact that parole officers draw a considerable amount of money. The average parole officer is going to make at least \$30,000.

Senator SPECTER. I was just asking, Mr. Palmer.

Mr. PALMER. They would make at least \$30,000, and we have to pay for the hospitalization and the benefits. I am learning the budget pretty well now, so you know, when I give you these figures, I have thought about it.

Senator SPECTER. How about the people who are on parole? What kind of evaluation do you have for those? Do all those have to stay on parole?

Mr. PALMER. Not necessarily, sir. But, again, we believe in safe and secure facilities, and the criticisms that we have, so we try to keep things pretty well—

EVALUATION OF PAROLE SYSTEM

Senator SPECTER. But every step of the way, when you release a man on bail, what do you sentence him to, when do you put him on parole, when do you take him off parole—all those are judgment calls.

What evaluation system do you have for determining whether somebody ought to stay on parole or not?

Mr. PALMER. We could go back to the parole officers and see how well they are doing, and I would say, Senator, that some of those persons could come off parole, in my opinion. We have persons who have been on parole for a long period of time, and have caused no problems, and they have readjusted.

CURRENT NUMBER OF PAROLEES

Senator SPECTER. How many people do you have on parole at the present time?

Mr. PALMER. Approximately 2,600.

Senator SPECTER. I would like an answer to the question, if you had somebody to evaluate those cases, to take a look at that, how many people might you be able to release from parole?

Mr. PALMER. I would safely say, Senator, if we had someone to do a real indepth study that we could release 20 percent of those people.

Senator SPECTER. Well, if you do that, you have eliminated the \$180,000. You have gotten 500 people off. In fact, you can give back \$180,000.

Mr. PALMER. The problem, Senator, with that argument, and I anticipated that, you take the parole officers and what they have to do and that figure is far different than the 300.

Senator SPECTER. What I would like to do is, I would like to see the analysis at all stages, and we have identified all the parts of it that I can think of, and if you can think of others I would like to see.

But this is the time. It will be a full year before we operate on this again, and we have only been able—I have been chairman for only the last few months, 6½ months—and I would like to come to grips with these issues and try to get some answers and try to give you some help on the spots where some money would do you a significant amount of good.

The one thing we haven't touched on, and I want to have followup with staff independently, is this issue of rehabilitation. What is it going to cost to see to it that people are not released as functional illiterates, and to provide vocational training?

We are going to have to break now.

Mr. PALMER. Senator, I have a plan to that next week, and I am very appreciative of the fact that you have only been on 6½ months, and I want you to know one thing. You and I came on about the same time. I came on January 2.

Senator SPECTER. Well, I hope you have a longer term than I have. [Laughter.]

Mr. PALMER. At the rate I am going, I don't know, Senator.

PREPARED STATEMENT

Senator SPECTER. Thank you very much. We have the prepared statement of Mr. Downs and it will be inserted in the record.

[The statement follows:]

STATEMENT OF THOMAS M. DOWNS

Good afternoon Mr. Chairman. I am Thomas M. Downs, City Administrator/Deputy Mayor for Operations.

Thank you for affording me the opportunity to offer some general comments about the problem of overcrowding in the District's correctional facilities. My comments will provide a general framework for resolving this problem within the overall context of managing the criminal justice system.

First let me iterate Mayor Barry's belief that insuring public safety is a priority he must maintain. Assurance of public safety, however, is a complex issue that permeates the fiber of societal and governmental operations, thus requiring a delicate balancing of values and resources. The citizens and visitors to the District of Columbia must feel safe, therefore, our prevention, enforcement, and apprehension efforts must be active and well coordinated; our dispensation of sanctions for law violations must be quick and appropriate; and rehabilitation must be the objective in the administration of correctional services.

Moreover, all of these goals have to be accomplished within the fiscal reality of increased service demands and fewer resources. For the past 2 years, public safety expenditures have accounted for approximately one-fourth of District government expenditures, resulting in an annual expenditure in excess of \$350 million. When one weighs the need for buttressing the economic base through improvements in the areas of education, housing, job training and development, and the delivery of human services, it highlights the necessity for containing costs in public safety.

We are, therefore, placing greater emphasis on planning and coordinating among the criminal justice entities not only to reduce the prison population, but also to improve operations within and among the various components. Eighteen months ago, Mayor Barry created a broad based Commission on Crime and Justice to assess the crime problem, make specific recommendations and monitor implementation of the improvement plans. A further outgrowth of that effort was the creation of a Justice System Board, comprised of principals from criminal justice agencies, along with the Superintendent of Schools and Chiefs of the Park and Capitol Police forces. This Board is chaired by Mayor Barry and addresses the operational issues inherent in making systemic changes, as well as in implementing short- and long-term strategies involving legislative and procedural changes. The Board receives guidance from national experts provided by the National Institute of Corrections. These joint efforts provide the working framework and knowledge, gained from experiences of other urban areas and States that are confronted with similar problems of serious crime rates and overcrowded prisons.

In calendar year 1981, the number of reported crime index offenses reached 68,338, the highest level reported since 1971. As the incidence of reported crimes increased, there was a corresponding increase in adult arrests for crime index offenses rising from 8,716 in 1980 to 9,242 for 1981. Changing conditions and increased law enforcement activity have led to a slight decline in the number of reported crime index offenses for 1982 which decreased by 3 percent in comparison with the previous year. A corresponding decrease in adult arrests also occurred in 1982, declining by 4 percent when compared with the previous year. Thus far in calendar year 1983, reported crime index levels continue to indicate a gradual declining trend.

It would perhaps be helpful to provide you with an overview of recent criminal justice activity in the District of Columbia:

1. Law enforcement

In the area of law enforcement, the Metropolitan Police Department is striving to increase its effectiveness through better deployment of resources and design of police beats and district boundaries according to prevailing crime patterns. Pilot programs have been undertaken that target groups such as career and repeat offenders, drug traffickers, escapees, felons wanted on bench warrants, and parole violators. These programs include the narcotics task force which is responsible for cleanup operations in the District's major known drug corridors, identification and apprehension of selected known career criminals, and identification and surveillance of high risk robbery locations.

II. Citizen participation (prevention)

Citizens are being encouraged to take a more active role in making their neighborhoods and businesses secure. Numerous crime prevention programs have been initiated over the last several years in the District including "Neighborhood Watch" which currently has over 50,000 households participating, and "Project Identification" where police officers assist citizens in labeling their personal property. Citizens are also being encouraged to report crimes and to provide information that may be pertinent to police efforts to solve them.

III. Pretrial status

After an alleged offender is apprehended, the next key decision point in the criminal justice process is the pretrial status determination. Alleged offenders are either detained while awaiting trial or released to the community under a wide range of conditions. In July 1982, the District's pretrial detention law was amended to facilitate the pretrial detention of dangerous defendants. The impetus for this change came from increased public concern regarding crimes committed by defendants while on release. While recognizing the importance of detaining some defendants prior to trial in order to enhance public safety, the executive branch is also committed to expanding pretrial release opportunities for other defendants who pose only a minimal risk to public safety. Efforts are being undertaken to expand existing third party custodial programs that would provide supervision of defendants while on release awaiting trial. In addition to these measures, the executive branch will work closely with the U.S. attorney and the courts to expand existing diversion programs for arrestees charged with non-violent crimes.

Over the past several years, the local courts have been subjected to greater caseloads as a result of increased crime and arrests. The number of cases filed for criminal prosecution rose to 17,928, which is nearly 4,000 cases more than reported for 1978. Because of the larger caseload, the judiciary's ability to process cases expeditiously is strained. Recently, additional hearing commissioners were appointed who will help alleviate existing backlogs. However, the executive branch continues to work closely with the local courts to develop additional measures that will accelerate the flow of cases through our judicial system.

IV. Expansion issues

For the past several years, the District has pursued a policy of modest expansion of prison space. The advantage of maintaining a position against even greater expansion is that millions of dollars in construction and operating costs can be avoided. Prison resources are scarce in terms of demand for services, and the executive branch is pursuing a policy that hopefully will reserve costly prison space for those who present a danger to the public, and for those who are unable to appropriately respond to non-incarcerative conditions. Over the coming months, the executive branch, in conjunction with the court and other public safety entities, will strive to develop creative sentencing options for those offenders who are best handled in nonincarcerative settings.

V. Parole

Relative to specific strategies targeted at reducing the sentenced population, the Mayor will initiate efforts to expedite the parole process for certain categories on non-violent offenders, and thus have them reviewed by the Parole Board 3 to 6 months earlier than currently allowed whenever more bed space is required for newly sentenced serious offenders. As mentioned in Mr. Palmer's statement, more institutional and community spaces are being considered. Additionally, screening and training of correctional staff are being improved. The use of volunteers in procuring resources and providing direct services to inmates has been expanded, primarily through the Washington Correctional Foundation.

In summation, the Mayor is greatly concerned about the problems of crime and prison overcrowding. This concern was translated into proactive, ongoing strategies involving the entire community. It takes into consideration the often competing social and economic needs of our citizens relative to the resource demands required for assurance of public safety. We will not let this problem continue to be treated as a series of small incremental problems.

SUBCOMMITTEE RECESS

Senator SPECTER. The hearing is adjourned.

[Whereupon, at 2:55 p.m., Wednesday, July 13, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, July 20.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

WEDNESDAY, JULY 20, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10 a.m. in room SD-124, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

Staff present: Tim Leeth, counsel, and Mr. Bowman, counsel.

DISTRICT OF COLUMBIA

BOARD OF PAROLE

STATEMENTS OF:

BERNICE JUST, CHAIRMAN, D.C. BOARD OF PAROLE

STANLEY HARRIS, U.S. ATTORNEY FOR THE DISTRICT OF COLUMBIA

ACCOMPANIED BY:

H. ALBION FERRELL, D.C. BOARD OF PAROLE

JOHN GIBSON, D.C. BOARD OF PAROLE

JOSEPH E. DEGENOVO, PRINCIPAL ASSISTANT U.S. ATTORNEY

EDWARD D. ROSS, JR., ASSISTANT U.S. ATTORNEY AND DIRECTOR,
SUPERIOR COURT OPERATIONS

OPENING STATEMENT

Senator SPECTER. Good morning, ladies and gentlemen. The hour of 10 having arrived, we will begin the hearing before the Subcommittee on the District of Columbia of the Committee on Appropriations. We meet this morning to consider the District of Columbia Board of Parole. This spring, we began hearings on all aspects of the District of Columbia's budget and our intention was to obtain a general overview of the District first, and then to concentrate on areas deserving special attention at a later time.

This is another in a series of such followup hearings.

Last week, we heard from the Department of Corrections, Director James Palmer, and from the City Administrator, Thomas Downs. They testified about the serious overcrowding at the D.C. detention facility, which I had an opportunity to observe earlier this year on a visit there

with Mayor Barry, and about other problems facing the D.C. corrections system.

The hearings detailed a serious problem, but several concrete proposals have emerged involving expanding capacity, speeding up parole considerations for those eligible, where consideration can appropriately be given consistent with the safety of the community, and finding jobs for those who would be paroled but for lack of employment.

We also learned that the Board of Parole is obviously active in these questions, involved in these questions, and the overall corrections equation. No other organization, certainly no single judge, has as much say about who should be incarcerated and who should not be as the Board of Parole, which must make fundamental decisions on whom to release and when.

The Board is put in the obviously difficult position of judging when an inmate is ready for reintegration into society so that he or she will no longer pose a danger. Those who are ready should, of course, be processed for parole, depending on their own circumstances, but should not be held up for lack of resources in the parole process.

That is to say, the process of giving them consideration in a timely manner.

Many remain too dangerous for public safety, and of course that is a judgment for the Parole Board. Today, the subcommittee hopes to learn more about the organization of the Parole Board, whether sufficient resources are now devoted to support work, and how it goes about making its decisions.

We also hope to learn more about the recidivism rate for persons already paroled. I am told the figure is 52 percent. That, quite frankly, is an alarming figure. We will explore it further this morning.

We will also be interested to learn what educational and vocational opportunities have been made available to parolees and what effect they have on recidivism.

We have very distinguished witnesses today, the Honorable Bernice Just, the Chairman of the Board of Parole, and the Honorable Stanley Harris, U.S. Attorney for the District of Columbia. Welcome.

Chairman Just, we appreciate your being here, and we look forward to your testimony.

STATEMENT OF BERNICE JUST

Ms. JUST. Thank you, Mr. Chairman.

With me this morning are H. Albion Ferrell and John Gibson, my fellow Board members. We appreciate this opportunity to discuss with you the subject of parole in the District of Columbia. I shall give you a brief overview of the Board's operations and then try to answer your questions.

By statute, the D.C. Board of Parole is composed of three members. We are appointed by the Mayor. The term of office is 6 years. Our charge is to determine when and under what conditions it is appropriate to return a prisoner to the community to continue the service of his or her sentence under parole supervision. It is also our duty to determine when and under what conditions to return a parole violator

to incarceration. In addition, we are responsible for making recommendations to the court with reference to sentencing under the Youth Corrections Act and for reduction in minimum sentence.

Section 24-204 of the D.C. Code states:

Whenever it shall appear to the Board of Parole that there is a reasonable probability that a prisoner will live and remain at liberty without violating the law, that his release is not incompatible with the welfare of society, and that he has served the minimum sentence imposed or the prescribed portion of his sentence, as the case may be, the Board may authorize his release on parole upon such terms and conditions as the Board shall from time to time prescribe. While on parole, a prisoner shall remain in the legal custody and under the control of the Attorney General of the United States or his authorized representative until the expiration of the maximum of the term or terms specified in his sentence without regard to good time allowance.

POWER OF THE BOARD OF PAROLE

The power of the Board of Parole extends to all prisoners whose sentences exceed 180 days, regardless of the nature of the offense. In those cases where a minimum-maximum sentence is imposed, the Board's jurisdiction begins only when the minimum term has been served. In misdemeanor sentences, the Board's jurisdiction begins at the completion of one-third of the sentence. In Federal Youth Corrections Act cases, the Board's jurisdiction is immediate.

We have developed guidelines which are used as an aid in examining the factors relating to the parole decision. These include: Seriousness of present offense; risk of rearrest/revocation; institutional discipline; prison program participation; assaultive potential; seriousness of prior criminal record; social stability, and substance abuse potential.

Before authorizing a prisoner's release, the Board requires documentation of residence and employment.

Revocation proceedings follow the issuance of a parole violator warrant charging violation of one or more conditions of parole. The Board has three options available to it in such proceedings: (1) To revoke parole; (2) to reinstate the parolee to supervision, and (3) continue the warrant in effect pending further decision. Parolees who come before the Board for a revocation hearing are entitled to have legal counsel and to present witnesses in their behalf.

All case decisions require the agreement of two Board members. Decisions concerning a reduction in minimum sentence must be unanimous.

BOARD OF PAROLE CASELOAD

Our hearing caseload is approximately 350 cases per month. We now have the assistance of two hearing examiners who conduct preliminary parole and revocation hearings. Their recommendations are brought to the Board for final decision. In addition, the Board members convene in panels of two to conduct direct hearings.

Institutional hearings scheduled for the month of July 1983, are as follows, and I will read the name of the institution and the number of inmates to be heard at that institution. Central Detention Facility, 138. That, by the way, is what is also called the D.C. jail.

The Lorton Central Facility, 42; the Lorton Maximum Security Facility, 14; the Lorton Minimum Security Facility, 10; Youth Center I, 42; Youth Center II, 28; Occoquan, 42; Work Release Centers, 31. That adds to a total of 347 inmates who will be heard this month.

Finally, I am offering an example of a typical workweek. On Monday, the Board is in office docket, at which time we consider perhaps up to 150 cases. The hearing examiner is at the Central Detention Facility.

On Tuesday, the Board may be at Youth Center II, conducting parole hearings. The hearing examiner will be at the Work Release Center conducting parole hearings.

On Wednesday, the Board may be at Youth Center I conducting revocation hearings. The hearing examiner may be at Youth Center II conducting initial hearings.

On Thursday, the Board will be at the central complex, or at maximum, conducting parole hearings. The hearing examiner may be at Occoquan conducting parole hearings.

On Friday, the Board will be at the Central Detention Facility conducting revocation hearings, and the hearing examiner may be conducting personal appearance hearings in the office.

This is a very brief overview of the Board's operations, and we will be glad to answer any questions you may have at this time.

PREPARED STATEMENT

Senator SPECTER. Thank you, Chairman Just. Your prepared statement will be inserted in the record. We will proceed with the questions. [The statement follows:]

STATEMENT OF BERNICE JUST

Good morning, Mr. Chairman. With me this morning are H. Albion Ferrell and John Gibson, my fellow Board members. We appreciate this opportunity to discuss with you the subject of parole in the District of Columbia. I shall give you a brief overview of the Board's operations and then try to answer your questions.

By statute the D.C. Board of Parole is composed of three members. We are appointed by the Mayor. The term of office is 6 years. Our charge is to determine when and under what conditions it is appropriate to return a prisoner to the community to continue the service of his or her sentence under parole supervision. It is also our duty to determine when and under what conditions to return a parole violator to incarceration. In addition we are responsible for making recommendations to the court with reference to sentencing under the Youth Corrections act and for reduction in minimum sentence.

Section 24-204 of the D.C. Code states:

Whenever it shall appear to the Board of Parole that there is a reasonable probability that a prisoner will live and remain at liberty without violating the law, that his release is not incompatible with the welfare of society, and that he has served the minimum sentence imposed or the prescribed portion of his sentence, as the case may be, the Board may authorize his release on parole upon such terms and conditions as the Board shall from time to time prescribe. While on parole, a prisoner shall remain in the legal custody and under the control of the Attorney General of the United States or his authorized representative until the expiration of the maximum of the term or terms specified in his sentence without regard to good time allowance.

The power of the Board of Parole extends to all prisoners whose sentences exceed 180 days regardless of the nature of the offense. In those cases where a minimum-maxi-

imum sentence is imposed the Board's jurisdiction begins only when the minimum term has been served. In misdemeanor sentences the Board's jurisdiction begins at the completion of the minimum sentence. In Federal Youth Corrections Act cases the Board's jurisdiction is immediate.

We have developed guidelines which are used as an aid in examining the factors relating to the parole decision. These include: Seriousness of present offense; risk of rearrest/revocation; institutional discipline; prison program participation; assaultive potential; seriousness of prior criminal record; social stability; and substance abuse potential. Before authorizing a prisoner's release the Board requires documentation of residence and employment.

Revocation proceedings follow the issuance of a parole violator warrant charging violation of one or more conditions of parole. The Board has three options available to it in such proceedings: (1) To revoke parole; (2) to reinstate the parolee to supervision; and (3) continue the warrant in effect pending further decision. Parolees who come before the Board for a revocation hearing are entitled to have legal counsel and to present witnesses in their behalf.

All case decisions require the agreement of two Board members. Decisions concerning a reduction in minimum sentence must be unanimous.

Our hearing caseload is approximately 350 cases per month. We now have the assistance of two hearing examiners who conduct preliminary parole and revocation hearings. Their recommendations are brought to the Board for final decision. In addition Board members convene in panels of two to conduct direct hearings.

Institutional hearings scheduled for the month of July 1983 are as follows:

Institution:	Number of inmates to be heard
Central Detention Facility.....	138
Lorton Central Facility.....	42
Lorton Maximum Security.....	14
Lorton Minimum Security.....	10
Youth Center I.....	42
Youth Center II.....	28
Occoquan.....	42
Work Release Centers.....	31
Total.....	347

The following is an example of a typical workweek:

Monday: Board in office docket, hearing examiner at Central Detention Facility.

Tuesday: Board at Youth Center II, hearing examiner at Work Release Center.

Wednesday: Board at Youth Center I, hearing examiner at Youth Center II.

Thursday: Board at Central Complex, hearing examiner at Occoquan.

Friday: Board at Central Detention Facility, hearing examiner conducts personal appearance hearings in office.

This is a very brief overview of the Board's operations.

MEMBERS OF BOARD OF PAROLE

Senator SPECTER. Who are the three members of the D.C. Board of Parole?

Ms. JUST. Mr. H. Albion Ferrell, Mr. John L. Gibson, whose term of office started yesterday, and myself, Bernice Just.

Senator SPECTER. So we have the entire board with us this morning.

Ms. JUST. Yes, we have.

TERMS AND COMPENSATION OF BOARD MEMBERS

Senator SPECTER. We appreciate your being here. And these are 6-year terms?

Ms. JUST. Yes.

Senator SPECTER. What is the compensation, if any?

Ms. JUST. We are a full-time board, and we are compensated—in fact we are classified—as DS-15.

Senator SPECTER. And that compensation is how much a year?

Ms. JUST. I don't know. I understand that \$48,000 is step one of that grade.

BACKGROUND OF BOARD MEMBERS

Senator SPECTER. What is your background, very briefly?

Ms. JUST. Mine is a rather extensive background in education, religious education, social service work, and most recently before coming to the Board, I worked for 9 years as a monitor of the criminal justice system in Washington, D.C., under the auspices of the American Friends Service Committee.

Senator SPECTER. Mr. Ferrell, what is your background, briefly?

Mr. FERRELL. Education, public and private school teaching. Seminary, Episcopal clergyman, former teacher, professor, at Howard University School of Religion. I have been on the Board for 20 years.

Senator SPECTER. Mr. Gibson, what is your background, please?

Mr. GIBSON. Professionally, I am a business and management consultant, and for the last 8 years have been working in the District of Columbia on a volunteer basis as a member of the Citizens Advisory Committee to the D.C. Bar. I was a nonlawyer member of the D.C. Bar Board of Governors for 4 years. For the last 4 years, I have been a member of the Board of Trustees of the Public Defender Service. And I have also worked in the District of Columbia as a personnel management analyst.

Senator SPECTER. Then, from the backgrounds you have outlined, none of you is a member of the bar association? No one is a lawyer?

Ms. JUST. That is correct.

Senator SPECTER. Does any of you have any background or experience in law enforcement work?

Ms. JUST. Not to my knowledge.

CRITERIA FOR GRANTING PAROLE

Senator SPECTER. Let us begin with the criteria which you outlined, Chairman Just. Could you expand on how the Board makes a determination of reasonable probability that a prisoner will live and remain at liberty without violating the law? That's the D.C. Code.

Ms. JUST. That is correct.

Senator SPECTER. Those words are, of course, subject to broad interpretation, but could you give a further definition as to how the Board applies those terms?

Ms. JUST. We have available to us—and I hope at any point Mr. Ferrell will feel free to augment what I say—we have available to us at the time of the parole hearing a presentence report that was prepared for the court prior to sentencing. It has the institutional progress report which describes the entire experience of the person within the institution. This would include a description of the programs in which he or

she has participated, the institutional disciplinary record, and again, more on social background.

There is also some indication of the evidence of community support that has appeared over the period of confinement.

Mr. FERRELL. Well, I would say there is an effort to understand the dynamics of how the person got involved in this particular offense in which he was involved, what efforts he has made at self improvement according to the facilities that are available in the institution, and what possible supports are available for him if released into the community.

That would include a family, religious, social, and other kinds of activities. What particular problems he has, and this includes substance abuse, drugs, alcohol, and a proclivity in that direction.

On an assessment as to the—how does one express it?—sincerity with which the potential parolee approaches the whole process.

RECOMMENDATION FROM INSTITUTION

Senator SPECTER. And who do you customarily hear from? You hear from the applicant?

Mr. FERRELL. There is a progress report that is prepared from the institution.

Senator SPECTER. Does the institution make a recommendation?

Mr. FERRELL. The institution makes a recommendation. In fact, the caseworker makes his individual recommendation.

Senator SPECTER. How frequently do you follow the recommendation of the institution?

Mr. FERRELL. I would say 78 or 80 percent of the time.

Senator SPECTER. And the times that you do not follow it, do they customarily recommend release and you disagree, or—

Mr. FERRELL. Either way.

USING RECOMMENDATIONS FROM INSTITUTIONS

Senator SPECTER. How much of the time when they recommend release do you disagree with them? Could you compile those statistics? We would be interested to know them, if that is available.

Ms. Just We could supply a very brief sample. We do not have a computer capability at this point. We expect to have one starting next week. So that all our statistics are laboriously gathered by hand count. But if you could accept a sampling over a period of a week out of a month, or something on that order. I don't know how extensive a statistical picture you would want.

Senator SPECTER. If you would give us a picture, say, for a month or two, that would be helpful, if that would not burden you unduly. Say 6 weeks, if you could give us a study. Why don't you pick the 6 weeks, say, from February 1 to March 15.

What I would be interested to know is how many applications you heard, how many the institution recommended for parole, and how many you agreed with them on, and how many they opposed parole, and how many you agreed with them on.

Ms. JUST. All right.
[The information follows:]

APPLICATIONS HEARD BY PAROLE BOARD

During the period between February 1, 1983 and March 15, 1983, the Board heard 205 applications for parole.

(a) Of the 121 grants of parole during this period, the Department of Corrections recommendation and the Board's action were congruous in 117 of the cases. There were only 4 instances (3 percent) in which the Board granted parole to inmates whose release was not supported by the institution.

(b) During this period, 84 applications for parole were denied or continued. Of this number, 80 were opposed by the D.C. Department of Corrections. There were only 4 instances where the Board denied parole to an inmate whose release was supported by the Department of Corrections.

RANKING OF CRITERIA USED IN GRANTING PAROLE

Senator SPECTER. I notice on the factors which you list, there are eight of them, and seriousness of prior criminal record is number six on that list. Are you ranking the factors in importance as you consider them, because if you are, it seems to me that the seriousness of the prior criminal record is—

Mr. FERRELL. No; they are not ranked in importance.

Senator SPECTER. They are not.

What kind of a weight would you give to the seriousness of a prior criminal record?

Ms. JUST. Those factors are given equal weight.

Senator SPECTER. Equal weight?

Ms. JUST. Yes.

Senator SPECTER. It would seem to me that in the evaluation of an individual, the prior record would be a very important factor in terms of trying to predict future conduct. What is your thought on that?

Ms. JUST. I agree, it is.

RECIDIVISM OF PAROLEES

Senator SPECTER. As I outlined in the opening statement, based on information provided me by staff, the statistics show that the recidivism rate for those who are paroled is 52 percent. Is that an accurate figure?

Ms. JUST. I believe it is 40 percent.

Mr. FERRELL. That would seem to be very high, Senator. I think I need to make another kind of statement, that the recidivism rate includes both adult and Youth Act offenders.

Now, the Youth Act offenders have a rate of recidivism considerably higher than the adult offenders, and there are logical reasons for this.

The Youth Act in its very genesis, emphasizes that it is directed toward treatment. When the institution advises the Parole Board that a young man has completed the program outlined for him successfully, which in their opinion suggests that he has mastered whatever difficulties he had, he is recommended to the Board for release.

The Board then makes the decision to release or not to release. Now, at the youth center, those recommendations are followed, I suppose, 90 percent of the time, probably a little higher. There is a difference when the young man is released into the community.

There is the very nature of the release itself, involving employment, social status, the availability of social programs, and they are given a much higher degree of supervision than would be true of the adults. So they would be returned probably a lot faster because of kinds of technical problems than would an adult person. That is the reason the Youth Act figures would be considerably higher.

Senator SPECTER. Mr. Ferrell, I have just had handed me a document designated table 1, which is a study made from 1977 through 1979, and it lists all parolees, total release of 322, and 167 sustained new arrests, which is the 52-percent figure.

Ms. JUST. May I speak to that, Mr. Specter?

Senator SPECTER. Yes.

Ms. JUST. I found what I was looking for in our annual report. It is true that 52 percent sustained new arrests in that 2-year period. The report shows that 40 percent sustained new convictions, while 60 percent remained conviction free.

Now, again, this was a sample based on every 10th name from the entire roster of people who were granted parole over that 2-year period.

Senator SPECTER. What is your evaluation of a situation where you have 52 percent sustaining new arrests and 40 percent sustaining new convictions, Chairman Just?

Ms. JUST. I think that I would attach more credence to the 40-percent figure than to the 52-percent figure for the reason that, whatever the proportion might be, not everyone who is arrested is in fact—

Senator SPECTER. Take the lower figure, 40 percent. What is your evaluation of that?

Ms. JUST. It is my impression that that is not out of line with national figures, but once again I don't have those before me. We have investigated that once or twice in the past.

I would say that with respect to making a parole decision that the 40-percent figure has been—may have been—pretty constant over the years. We don't have a long record of statistics, but what this says to me is that the Board is called upon to make a judgment as to a person's likelihood of succeeding on parole, and what this is saying is that based on our own records, in 60 percent of the cases we have been—our judgment has been—vindicated over a 2-year period, and in 40 percent it hasn't.

That same study that you have there, I think, shows a time lapse of the greatest number of arrests coming within the first 8 months. I think that is found to be the most critical period, and if the person succeeds past the eighth month, then the chance of remaining successful on parole seems to increase.

GRANTING PAROLE TO RELIEVE OVERCROWDING

Senator SPECTER. To what extent are you pressured or pressed or influenced to release on parole because of overcrowded conditions at the institution?

Ms. JUST. This has not been primary in our thinking. Of course, we cannot be unaware of the fact that the public safety is also affected by

overcrowding at the institutions, but that has never been our primary consideration.

Now, in a marginal case, particularly with reference to the issuance of a warrant, we may tilt toward not issuing the warrant unless the evidence is just very clear and strong that to protect the public safety we need to.

So what I am saying is that this is not the primary focus in our decision, nor does it appear anywhere as a factor in our decisionmaking process.

EVALUATION OF CONVICTION RATE

Senator SPECTER. What is your evaluation of the 40 percent, Mr. Ferrell, the 40-percent conviction rate?

Mr. FERRELL. I am not sure, Senator, whether that figure breaks down in terms of felonies and misdemeanors, or whether it is a composite figure for both.

Ms. JUST. Composite.

Mr. FERRELL. Well, let me say first of all that the District of Columbia, unlike any other jurisdiction in the country which has a parole board, is an entirely metropolitan jurisdiction. It is not, for example, like your State of Pennsylvania, where you have broad areas of rural, semirural, and metropolitan figures. All of the District of Columbia is in a highly metropolitan area. That is the first thing I would observe.

The second thing I would observe is that the District of Columbia is very heavily influenced at this point, and over recent years, there has been a heavy influence or influx, of narcotic drugs of various kinds, heroin, cocaine, and with the youngsters, marijuana, PCP, and that sort of thing.

Now, an arrest and conviction for marijuana shows up in the statistics as an arrest toward that 40 percent. You probably know that the great majority of youngsters not only in Washington, but throughout the country, do not have the same appreciation of the marijuana problem as do you and I.

So what I am saying is that although the figure of 40 percent is there, it needs to be looked at in terms of what composes that 40 percent. My guess, my strong guess, would be that of that 40 percent, oh, somewhere between 60 and 75 percent would be misdemeanor convictions, a large number of which would be for drug use of such things as marijuana and PCP, which to us are important, but to the general population in the city it just does not carry the same kind of weight it does with us.

Senator SPECTER. Mr. Ferrell, your speculation may be accurate, or it may be inaccurate. We don't know. My own sense is that where you have a 52-percent arrest rate and a 40-percent conviction rate, that those are very high figures.

What I would like to see is a refinement to see if you are right or wrong, if there are explanations which would justify a conclusion that the 40-percent figure is not alarming because of other factors, that there may be minor—

Mr. FERRELL. I don't mean to say—please understand me, Senator—I do not mean to say that it is not alarming. Even if the 40 percent consisted entirely of misdemeanor offenses, it would still be alarming. My point is that it would not be as alarming as if there were 40 percent felony convictions.

Senator SPECTER. Well, Mr. Ferrell, if it reaches the alarming level, which you and I appear to agree on, then the next question is what do we do about it? Is there an appropriate standard for release? Obviously this is a judgment for the Parole Board.

I do not seek to—and this committee does not seek to—substitute our judgment for your judgment, but we do have a supervisory role.

Mr. FERRELL. I understand that.

Senator SPECTER. And part of that role is the question of funding which we are on, and evaluation, and if we are dealing with an alarming figure, I would ask the Board to refine these figures, to get an update on the figures, and to go beyond that and try to make a determination as to what—if there is any pattern among those who have been rearrested and reconvicted, you can learn from that experience in terms of future parole decisions.

That is a constant effort. I have seen from work in this field that the statistics are frequently insufficient, but that is the kind of an inquiry that the subcommittee would appreciate your making and reporting back to us on.

[The information follows:]

SUCCESS/FAILURE RATE OF PAROLEES

The Board of Parole lacks the staff power and technological capability to update the aforementioned research in a timely and methodologically sound fashion. The Board has recently created a position of Director of Research, Planning, and Data Systems; the position is to be filled by October 1. Thereafter, the Board should possess the wherewithal to update this critical analysis.

In the interim, the Board has undertaken an analysis of its Revocation Hearings conducted between February 1, 1983 and March 15, 1983. The following are revealed:

Revoked.....	47
Reinstated to supervision.....	11
Continued supervision pending disposition of charges	15
Total hearings	73

RECOMMENDATIONS FROM LAW ENFORCEMENT AGENCIES

Senator SPECTER. Do you have recommendations from any law enforcement officials at the time you make these decisions? Do you customarily hear from the U.S. attorney or the chief of police?

Ms. JUST. Very frequently we do. Our procedure, of course, is always to notify the police of anyone who will be released. It has been the practice of the U.S. attorney's office at times in the past to send the Board a letter stating its objections to the release of someone on parole.

Senator SPECTER. On the studies which you undertake in response to our requests, we would appreciate it if you would figure into the statistics the number of times law enforcement officials have objected, and what your responses have been on those cases and what happened in those cases if you can make that determination.

[The information follows:]

During the course of this inquiry the Parole Board staff reviewed approximately 600 case files which represent the Board's total hearing caseload between February 1, 1983, and March 15, 1983. Based upon this review we find no instance of the various law enforcement agencies having expressed opposition to the Board's decision to release an inmate.

BACKLOG IN PROCESSING PERSONS FOR PAROLE

Senator SPECTER. Moving to a slightly different subject, we heard testimony from the Corrections Department last week that there is a backlog of people who are being processed for parole. My recollection is that the figure was about 350, where there is a backup, and you can't get to them fast enough because of insufficient administrative personnel. Is that consistent with your understanding of the facts?

Mr. Ferrell I am not quite clear as to—

Ms. JUST. We are right at this present time, Mr. Specter, trying to verify that figure also. We are trying to verify it from a list that just came over to me last night from the Department of Corrections. I had hoped to have a definitive figure for you today. Unfortunately, this list does not include the people who are in the Occoquan facility.

However, there is not a total shown here, so I am not able to say how many names are included there, but it appears that from this list there was a total of 83 people with parole eligibility dates—no, let me change that—a total of 101 people with parole eligibility dates, ranging from July 1975 through July 1983. That includes, of course, people whose parole has been revoked, and again we have not had the opportunity yet to identify among that list of 300, whatever it is that you were told last week; how many of those are in some kind of detainer status, how many have had their parole revoked.

I do know that we are currently abreast of all parole eligibles for whom the progress report has been received.

Senator SPECTER. Perhaps the progress report has not been received. Perhaps the tieup comes from the Department of Corrections, in not giving you a progress report.

Mr. FERRELL. That is right.

Senator SPECTER. What I think the subcommittee would like to do would be to pursue this question, give you an opportunity to get the information for us as to what is the status of those who are eligible for consideration.

It may be that the tieup is not with the Parole Board, but is with the Corrections Department in processing the information.

Mr. FERRELL. I know, for example, Senator, that at the Lorton complex, there are a number of cases which are eligible, but have not been heard because the progress reports, I am informed, have been prepared by the caseworkers, but have not yet come out of the typing pool.

Senator SPECTER. That is what we want to inquire into. What I think that the subcommittee will do will be to schedule a hearing, say, 2 months from now, some time in mid-September where we can take an updated look at it, and to give you an overview as to what the subcommittee is concerned about. I have discussed this with the Mayor, the picture extends from the time of arrest through the time of parole, and

there is a question of resources. One of the issues on arrest is whether the bail is being appropriately set, and there is an overcrowding in the D.C. jail, which we all know. The figure is somewhere around 2,400 for a facility which can accommodate 1,335. There are 700 in the D.C. jail who have been convicted and should not be there, but they cannot be sent to Lorton, because Lorton is at capacity, and both institutions are operating under a court order.

If a problem arises as to the trial process, we are trying to respond with 7 new judges and 21 assistant U.S. attorneys to try to bring cases to trial more promptly so that those who are convicted can be retained in custody, and those not convicted will be released.

On the other end comes the problem of processing people who are eligible for parole and, as I say, the figure of 350 has been given, which may not be the responsibility of the Board of Parole, but in the Department of Corrections. We want to make a determination of that.

It may be that there are more resources necessary in corrections to process them more promptly. It may be that the Board of Parole needs more resources. Part of your consideration may be, and I would like you to reflect on this, the crowded status of the prisons. That really should not be a consideration under ideal circumstances, and perhaps there has to be more space in prison to hold people who ought to be kept in prison, and that is something we are addressing, too, trying to find additional space for people who ought to be kept in prison. But the process extends from the arrest all the way through parole, and part of the evaluation requires the determination as to how successful your standards are.

No one is expecting you to be perfect, because nobody is, but when you talk about 52 percent, or even 40 percent, then you get into questions.

But that is the overview that the subcommittee is considering, and we want to be helpful to you.

NEED FOR ADDITIONAL RESOURCES

Let me ask you a final question: To what extent do you need more resources, as you see it at this moment, to perform your functions?

Ms. JUST. Well, as I stated earlier, we are working right now at full capacity. That is, if we were suddenly to be presented with 50 progress reports in addition to those hearings that have already been scheduled, we lack the resources to conduct those additional hearings.

So we are operating at top capacity at this time. I am hoping that we will be able to find whatever additional resources will be needed if there is an increase in our workload.

Senator SPECTER. We will certainly be prepared to consider your situation. Thank you for coming. Mr. Gibson, you will be substantially more experienced than you are at the present time.

Mr. GIBSON. I am sure.

Senator SPECTER. We welcome you to the Parole Board, having 1 day's service. It is good of you to come in to give us your views, and we will look forward to supplemental testimony from you when you return.

Thank you all very much.
 Mr. GIBSON. Thank you.
 Mr. FERRELL. Thank you.

INTRODUCTION OF U.S. ATTORNEY

Senator SPECTER. I would like to call now the Honorable Stanley Harris, the U.S. Attorney for the District of Columbia.

We know you would like to bring Mr. diGenova with you, Mr. Harris, if you choose to do so.

We welcome you, Mr. District Attorney, and your first assistant. We have some idea of the pressures and problems you labor under, and we will not keep you too long, but we do appreciate your coming.

The focus that we would like to start on—we welcome Mr. Ross as well—will be somewhat broader than the parole issue, but that is the central purpose of the hearing, and we will appreciate your testimony, Mr. Harris, and your observations on these issues.

Please proceed.

STATEMENT OF STANLEY S. HARRIS

Mr. HARRIS. Thank you, sir. I am happy to be here.

I might comment initially on part of Reverend Ferrell's testimony. He expressed the belief that there was no significant difference between the parole adjustment among Youth Corrections Act parolees and adult parolees.

On December 15, 1981, the Board of Parole itself issued an analysis of the performance of D.C. parolees during their first 2 years of parole supervision. One of the conclusions reached in that document reads as follows:

There appears to be no significant difference in overall parole adjustment between YCA parolees and adult parolees, although YCA parolees had a higher success rate during the first year of supervision. The adult parolees had a lower failure rate during the second.

So I think the record should stand corrected on that question.

The statistics which were referred to earlier, I think, might be brought together and highlighted somewhat. First, the Board of Parole has put out an annual report for the year 1982 that was issued in April of this year. It reflects, as was suggested, that there is a 52-percent rearrest rate of parolees during the first 2 years in which they are on parole.

There is an interesting breakdown in table 10 of that particular annual report. It shows that among those parolees who have been rearrested within those first 2 years after parole release, 25 percent were arrested within 1 to 4 months. An additional 31 percent are arrested between 5 and 8 months.

In other words, the total areas, the 56 percent of the 52 percent who are arrested within 2 years actually are arrested within 8 months.

Among the parolees who are rearrested, 80 percent are convicted. So that among all parolees, there is within the first 2 years a 40-percent conviction rate.

We are considerably troubled by the fact that only 20 percent of those parolees who have been released have their parole revoked. In other words, half of the rearrested and reconvicted parolees go back to do nothing on their remaining time on their original sentence. Their parole is never revoked.

Now, I hasten to add, sir, that I recognize that the Board of Parole undoubtedly has severe resource problems.

REVOCATION OF PAROLE

Senator SPECTER. What is the consequence after conviction? Is parole automatically revoked on conviction of the new charge?

Mr. HARRIS. It is not. In some cases it is revoked, and in half of the cases it is not.

Senator SPECTER. Even on conviction?

Mr. HARRIS. That is correct, sir, and it essentially never is revoked prior to conviction.

Senator SPECTER. Is there no hearing after arrest on the new charge to have some preliminary determination of the seriousness of the new charge and the level of evidence?

Mr. HARRIS. Well, let me take one example, concededly somewhat extreme, but it is one that we watched very closely. There was a parolee who was released. Five days later, a man with a sawed-off shotgun entered the rear door of a particular residence here in Washington and robbed three people in that house.

Ten minutes later, two men whose car matched the description and who matched the description were stopped. A sawed-off shotgun was found under the seat of the car. The men were taken back to the scene of the crime. The sawed-off shotgun was positively identified as having been the shotgun that was used in the robbery.

One victim positively identified the defendant, the parolee who had been out for 5 days. Two other witnesses tentatively identified the parolee, and the Board declined to issue a parole violation warrant.

Senator SPECTER. When did that case occur?

Mr. HARRIS. February 1982, sir.

Senator SPECTER. Is there a procedure for a complaint to be issued by your office, Mr. Harris, under such situations?

Mr. HARRIS. In this particular situation, we did write a letter to Mrs. Just expressing our concern about the handling of that particular case and requesting a response as to what happened.

She wrote back and advised us that their decision was based on what they perceived to be inconsistencies in the police reporting form, the so-called PD-163 form. We did not see any inconsistencies in that report.

Senator SPECTER. Has that case yet gone to trial?

Mr. HARRIS. We intended to check on that between last night and this morning, but unfortunately did not.

OVERALL EVALUATION OF PAROLE BOARD

Senator SPECTER. What is your overall evaluation, Mr. Harris, as to the performance of the Parole Board?

Mr. HARRIS. I think that the Parole Board certainly has limited resources. It certainly has people who are conscientious and well intentioned. In thinking about the Parole Board, I think of the Federal administrative agencies which have statutory provisions for no more than, say, a seven-member board, would have no more than four members from one particular party.

This parole board has unquestionably fine people. Basically, their orientation, their backgrounds, are social work, religious work, and those are fine fields. I have no quarrel with their backgrounds at all. However, there is a defendant orientation in the makeup of the Board, and I cannot help but conclude that the Board would have its functioning enhanced if there were more of a balance, if there were somebody with a law enforcement background on the Board.

What we have here in the District of Columbia, we have concededly a problem that is characterized as overcrowding in the jails, but I am not sure that that is really a fair characterization. I think a more accurate characterization is that we have an undercapacity in our jails. When people planned ahead, and of course the planning for jails takes a considerable period of time to plan and construct and finance them, I don't think anybody recognized the true extent of the effect of heroin and other drugs would have on the criminal element in a major metropolitan city such as Washington.

CAPACITY OF D.C. PRISON COMPLEX

Senator SPECTER. Do you know the total capacity of the D.C. prison complex?

Mr. Harris. I do not have those figures with me. I am sorry.

Senator SPECTER. The subcommittee would be interested in your judgment as to what the figures should be on capacity, and I am not asking you to give that to us now, but we would welcome it when you are able to do it.

I was at Lorton, but I do not recollect the capacity. I was at the D.C. jail more recently, and the capacity there, I know, is 1,335, and they have 2,400. We think it is about 3,000.

But we would be interested in your reflection on that, Mr. Harris, as to what you think the prison complex ought to be for the District of Columbia. There are moves afoot now in the Congress on the authorization of additional prison space, and the Justice Assistance Act, which has passed the Judiciary Committee with an add-on on legislation sponsored by Senator Dole and me, which adds money in for prisons. This would be a good time to sharpen our own thinking about the District of Columbia, as to what the capacity ought to be.

We would appreciate your sense on that.

[CLERK'S NOTE.—Subsequent to the hearing the following information was provided:]

The capacity of the District of Columbia's prison complex should be sufficient to house all D.C. prisoners, which on November 21, 1983 totaled 6,455. This includes those held in the detention center, Lorton prison, and Federal facilities.

EARLY PAROLE OF DANGEROUS PRISONERS

Senator SPECTER. Moving back to the central question as to the performance of the Board of Parole, what is your sense as to the rearrest record of the 52 percent, or reconviction record of 40 percent as a base for evaluation of the performance of the Parole Board? I am not asking now on a personalized sense, because that is not our objective, I think everybody knows. We are really looking to what the standards ought to be, and frankly how we get there.

Mr. HARRIS. Well, it is difficult for us to conclude anything other than that the Parole Board releases into the community too early many people who are too dangerous for proper release.

What you have, these reports issued by the Parole Board, they indicate that 61 percent of all inmates are paroled at the first opportunity at which they can be considered for parole.

James Palmer, the head of the Department of Corrections, testified before a House committee a few days ago that 85 percent of the Lorton inmates are recidivists. Another Lorton inmate also testified at this hearing, and he expressed the view that 115 percent of the Lorton inmates are violent recidivists.

Senator SPECTER. That averages out to 100 percent.

Mr. HARRIS. You have 61 percent being paroled at their initial hearing. You have 73 percent being paroled at their second hearing. So that in my view, particularly recognizing the high percentage, and there is an article in the Post on Sunday which I believe took the position that 65 percent of the Lorton inmates are heroin addicts. If you release a heroin addict on the street in Washington, you are releasing in effect a one-man crime wave on the street, and it is difficult for us to avoid the conclusion that inadequate consideration is given to the threat to the community of releasing some of these people who have proven records of violent recidivism.

We have a Chronic Offender Unit in the office which deals with the most violent recidivists. Now, one of the categories of people which we seek to prosecute with particular vigor in our Chronic Offender Unit is a person who is on release, either on probation or parole, for a prior crime of violence.

One-third of the people that we are now prosecuting in our Chronic Offender Unit are people who are on parole.

In other words, the Chronic Offender Unit takes only those who commit violent crimes while on release for having committed another prior violent crime, and one-third of our chronic offender intake people are parolees.

SUGGESTIONS FOR PAROLE BOARD

Senator SPECTER. Mr. Harris, would you have any suggestions for the Parole Board while they are within listening range?

Mr. HARRIS. Well, we have talked with them. Mrs. Just and I have become good personal friends. We meet on a regular basis to share our views. I have great respect for her. There is nothing unknown about how we feel about these things, and nothing unknown about how she feels. We share communication on a regular basis.

Senator SPECTER. Do you have any recommendations beyond simply tightening up the release standards?

Mr. HARRIS. Well, yes, as a matter of fact, we do have some, and some have been conveyed to the Board, in particularly one meeting, extensive meeting, that we had.

There are certain offenses which will trigger the release of a parole violator warrant by the Parole Board. There is one category which will trigger the release of the parole violator warrant. That is burglary of a residence.

One category which will not trigger the issuance of a parole violator warrant is burglary of a nonresidence, that is, a commercial burglary.

Now, in one period, and the figures are close to 16,000 or 17,000, something like that, burglaries in the last year, and of those 43 percent are commercial burglaries. Those are stores, some large, some small, some mom and pop stores, some tenants and office buildings. I frankly think that it is atrocious that that serious a crime does not justify the issuance of a parole violator warrant. We have a very sophisticated criminal population in this community, and I have not the slightest doubt but that everybody, or virtually everybody, knows that if they are on parole and burglarize a commercial establishment, that no parole violator warrant will be issued as a matter of policy by the Parole Board.

Senator SPECTER. Do your suggestions for change in Parole Board policy go more to issuance of warrants for violation of parole as opposed to standards for release on parole in the first instance?

Mr. HARRIS. The standards are rather nebulous, as you read and heard while they were here. Mrs. Just indicated that all of the factors that were enumerated in her testimony were rated equally, but then she agreed with your observation that somebody's prior criminal record ought to be heavily weighted.

I have never been privy to their decision process. It is difficult for me to comment on it. I do have problems with the end result.

RECOMMENDATIONS FOR PAROLE

Senator SPECTER. I know how limited your resources are. But do you have occasion to make recommendations on applications which are made for parole?

Mr. HARRIS. We have talked with the Parole Board and with Mrs. Just communicating the hope that we would be notified when a particular prisoner is going to be considered for parole so that we can check our records on him and make them available to them.

They have not been able to achieve giving us that notification. I don't quarrel with that or fault them for it. I am sure it is a matter of resources.

We would like to know when parolees are being released. We are not being advised of that at this time. There are many cases in which we have very, very detailed knowledge of how dangerous a particular prisoner is, and in which we would like to be heard as to letting that person back out on the street.

You asked about other thoughts. There is one other one that we have. If you again notice in their annual report, and this is the one for the year 1982, the eligible offenses for issuance of a parole violation warrant include firearm violations. Now, that is quite logical. But then there is a parenthesis, (when weapon is on the person of the parolee).

In other words, a parolee, perhaps with a history of multiple armed robberies who is apprehended in a car, and if the gun is under the seat or in his glove compartment, the Board of Parole says that, "That doesn't cause enough concern to issue a parole violator's warrant. He has to have it in his belt, or in a holster before we will issue a warrant."

That, to me, is troublesome, and that to me is undoubtedly perfectly well known to the criminal population in this community.

WAIVER AGE OF JUVENILES TO ADULTS

Senator SPECTER. Mr. Harris, let me shift to a couple of other topics while we have a chance to have your testimony for the record.

The Judiciary Committee had hearings yesterday on the issue of juvenile records. Mr. Gregory came in from the Office of Juvenile Justice and Delinquency Prevention, and we explored the question of somebody who turns 18—18 is the age in the District, is it not?

Mr. HARRIS. That is correct, sir, except by statute, certain enumerated offenses permit us to treat 16 and 17 year olds as adults. Those would include murder, rape, robbery, burglary, and assault with intent to commit any of those offenses.

Senator SPECTER. We are now considering some changes. The Judiciary Committee tomorrow is going to have a markup on the crime code, and one of the subjects we are going to take up is the subject of whether the age should be lowered to 15 on the discretionary changes, whether it ought to be lowered to 14. You didn't come to testify about that, but are you in a position to give us your judgment on that question?

Mr. HARRIS. Well, my off-the-cuff opinion is that some such move would be desirable. We do have larger and more violent, younger offenders now than we have ever had before.

Senator SPECTER. What age would you pick? Around 16?

Mr. HARRIS. Well, let me defer on that to Mr. Ross, who watches the flow in and out of Superior Court far more closely than I do.

Mr. Ross. Actually, I am not very well equipped, I think, to speak to this issue, either. We do have contact with some younger offenders, but most of our offenders are 16 years or older.

Senator SPECTER. How about the question of—

Mr. Ross. If I may, Senator.

Senator SPECTER. Yes, go ahead.

Mr. Ross. I think that at the very least a drop in the age to 15 would be appropriate, and in some instances I think it could be justified to reduce the age to 14.

The fact is that the District of Columbia also has a waiver provision for juveniles 15 and over. That has rarely been used by the Corporation Counsel's office because of the availability of the discretionary call on the part of the U.S. attorney's office. We are the ones to decide in a situation where a person is 16 years old or older. I think at the very least we would advance a view that the age ought to be lowered to at least 15.

USE OF JUVENILE RECORDS

Senator SPECTER. On the situation of availability of records, is the situation in the District of Columbia similar to most jurisdictions where a juvenile's record is not available? Say he is charged with an offense when he is 18½, and comes before an adult court.

Would that adult court customarily have access to his prior record as a juvenile?

Mr. HARRIS. The court would in a presentence report. That would, of course, follow conviction.

Senator SPECTER. And is that a matter of D.C. law, or a matter of Federal law, if you know?

Mr. HARRIS. I don't know that it is a matter of law at all. I think it is just a matter of policy or practice.

Well, there is a statutory language which limits the access of anybody to juvenile records. Only certain people for certain reasons can get them. We cannot get juvenile records ourselves for use in proceedings.

However, the Probation Department provides that information to sentencing judges after someone has been convicted.

Senator SPECTER. You think it is obviously desirable to have the sentencing judge on an 18-year-old who has been convicted to have access to his juvenile record?

Mr. HARRIS. I do.

Senator SPECTER. To make a determination on sentencing?

Mr. HARRIS. Because we have some who commit their first adult offense at age 18 who have a long history of violent juvenile crime.

Senator SPECTER. Do you think that the prosecuting attorney ought to have access to the record of juveniles if you are deciding the charge to make against an 18-year-old?

Mr. HARRIS. That is a difficult question. The concept of preserving the confidentiality of juvenile records certainly has validity, and I am not prepared to answer that. I don't feel that we are handicapped in any particular way in prosecutions in not having them.

U.S. ATTORNEYS PROVIDED IN LAST YEAR'S BUDGET

Senator SPECTER. The question that you and I discussed very briefly before the hearing began, Mr. Harris, involves the utilization of 18 assistant U.S. attorneys which were provided last year on an appropriation by the District of Columbia Subcommittee.

Will you tell us for the record what utilization you have made of those additional assistants?

Mr. HARRIS. Well, our office had gone through a period of a shortage of prosecutors. We had found it necessary prior to last year's legislation to move a number of our assistant U.S. attorneys from the District court side, the Federal side of our prosecutorial efforts, to the superior court side to be able to handle the unfortunately crushing workload over there.

That still was not adequate to stem the tide, and hence it was of enormous significance and help to us to be provided with 18 additional assistant U.S. attorneys.

We do receive an outstanding group of applicants. We were in a position to fill those positions quickly. They have been filled. They are being made excellent use of, and it has been an enormous help to us.

Senator SPECTER. When you were in to testify earlier on the overall criminal justice system and the chief judge was in, we explored the issue of expedited trials, the D.C. jail, and trial delay. The question arose as to the desirability of having seven additional superior court judges, that figure having been established in some preceding study, and at that time you, as I recall, testified that the regular ratio would be three new assistant U.S. attorneys for each new superior court appointment.

Mr. HARRIS. That is correct, sir. One of the things is a supplement to my answer to your prior question. Between the time that we were authorized the additional assistant U.S. attorneys and the time that we actually got them in place, the superior court was authorized to have three hearing commissioners, which freed up two additional judges to assume felony calendars.

So that six of the additional U.S. attorneys that we received through last year's bill were assigned to the two new felony judges that were just created.

Senator SPECTER. So you ended up with a net of 12 instead of 16 or 18?

Mr. HARRIS. That is right.

Senator SPECTER. And if we are successful in getting the appropriation and the authorization for 7 new superior court judges, then you would need the 21 assistant U.S. attorneys to staff those courts?

Mr. HARRIS. I don't know precisely what use would be made of those judges, but I assume 21 is a very sound figure, based upon the assumption of 7 judges, and certainly we would have a very real need for additional manpower.

Senator SPECTER. We don't control what the courts will do with their personnel, because that's the way it is, but we are hopeful that they will be used on criminal cases, be using them to get rid of the backlog.

Mr. HARRIS. I think that would be the very likely utilization of them.

180-DAY COURT RULE

Senator SPECTER. We are very hopeful that the court system would put in the 180-day rule. That is up to the court system as to what it will do, or other authorities in the District of Columbia, but we explored

that question, as I am sure you will recall, and the chief judge said he couldn't begin to do that unless he had 51 judges, and he will now have 51 judges if this all goes through.

Do you think there is a realistic targeting for a 180-day rule for the trial, from arrest to trial, given the exceptions that have been grafted onto similar rules in other States?

Mr. HARRIS. If you are talking about it as a requirement, I think it would be extremely difficult to live up to even with additional judges and prosecutors. I am troubled by rigid rules that say, "All right, if you try a person on the 180th day, that is fine. He may be found guilty and may be sentenced accordingly. If you miss it by 1 day, it is a free ride. The armed robbery that he commits goes by the board."

Senator SPECTER. The rules have been applied in other jurisdictions with some flexibility. The issue is coming to grips with some date. If there were flexibility as to its utilization, do you think it would be a target at that time?

Mr. HARRIS. Well, I am afraid that as just one representative of the Department of Justice who hasn't talked with anybody else at the Department about that problem that I should refrain from any other comment.

Senator SPECTER. We would appreciate your supplemental views on it, Mr. Harris, after you have had a chance to confer and reflect on it. Some trial time, I think, is coming everywhere, and this really is on the superior court side of the docket, and this is a judgment that is going to have to be made by the courts in conjunction with your office as an operating partner in that proceeding. It can't be done without your help and with the help of the defense bar and the defender's office, et cetera. We would appreciate your thinking on that.

Mr. HARRIS. I will simply add that, as I am sure you are well aware, those rigid time periods caused many problems for defendants and defense counsel as well as prosecutors.

Senator SPECTER. I know they do. The experience that I have seen, and I just offer this as an observation, and that as problemsome as the time periods are, they work out in the long run to establish parameters which are helpful to the system. They are hard to comply with.

In Pennsylvania, when we put in the 180-day rule, we got 9 extra months, as I recall it in Philadelphia because of the unique problems there. It was 270 days for a given period of time for an adjustment.

However you work it out based on your own problems, you have to see. What the subcommittee is trying to do is to respond to the hearing last year where the thought was expressed that if there were 7 new judges and 21 new U.S. attorneys, that would be the ballpark figure that the court would look to.

The court put the rule into effect in Pennsylvania. It was not the General Assembly. I suppose the D.C. government could put a speedy trial rule into effect if it chose to do so. Maybe even the Congress has the power to. Who knows.

CAREER CRIMINAL ACT

One of the subjects on which I would like to revisit with you very briefly before concluding the hearing, Mr. Harris, is the question of the Career Criminal Act. We have passed that through the Judiciary Committee again to see if we can bring to bear some Federal help on career criminals, and we have discussed it, I believe, on the record before.

The career criminal bill which passed last year was in a package which was ultimately vetoed. Seven bills were vetoed. It has a problem which the Justice Department expressed on having a veto by the local prosecutor in the jurisdictional section. It was section II which gave the court jurisdiction instead of section IV, which declared congressional intent, and the Department of Justice was concerned—we will only engage in the lawyer talk a few minutes, ladies and gentlemen, to set the stage—that if the State prosecutor could deny the court jurisdiction that there would be a Constitution infirmity, so we put it back into section IV.

That doesn't arise in your unique jurisdiction, Mr. Harris, where you wear both hats. You are the U.S. attorney for Federal purposes, and you are the U.S. attorney for the analogy for State court purposes.

What we are seeking to do, as for example in Philadelphia, we gave the U.S. attorney the authority with the consent of the district attorney, where someone has been convicted of two or more robberies or burglaries and is charged with a subsequent robbery or burglary with a firearm, there would be jurisdiction in the Federal court, and the thought is that there would be a limited number of Federal court prosecutions because the Federal courts have a tremendous burden at the present time, but it would be a great leverage factor, so that when the district attorney in Philadelphia has 500 career criminals that he can't bring to trial because they are judge shopping, or getting continuances, that if lightning strikes, three or four of them go to the Federal court and are subject to the speedy trial rules, and the mandatory minimum of 15 years in jail, and the advantages of the Federal court system that they will be less inclined to duck trial and more inclined to plead guilty.

I do not know if you and I discussed this specific situation, but I would be interested in your observation as to what effect that might have for you, since you wear both hats, where you could simply transfer a career criminal from your superior court docket to your Federal court, the United States District Court for the District of Columbia, whether that would give you leverage to deal with these career criminals in the superior court which you now do not have.

Mr. HARRIS. I believe it would.

Senator SPECTER. Well, that is something which we would like to process, and we are going to try to get it before the Senate before the recess, if we can, and get it passed and move it through the House.

There are some fascinating criminal law revisions which are in progress now, and I would be very interested to see. You have the best testing ground in your office for experience with that, where you could run the show out of your vest pocket or your jacket pocket.

Mr. HARRIS. That is true.

Senator SPECTER. We very much appreciate your coming. Thank you. We will be in touch as these problems continue to unfold.

Mr. HARRIS. Thank you, sir. Thank you for having us.

SUBCOMMITTEE RECESS

Senator SPECTER. The hearing is concluded.

[Whereupon, at 11:15 a.m., Wednesday, July 20, the subcommittee was recessed, to reconvene at 11:05 a.m., Tuesday, August 2.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

TUESDAY, AUGUST 2, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 11:05 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senator Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

STATEMENT OF DR. WILLIAM E. MAYER, ADMINISTRATOR, ALCOHOL,
DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC
HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACCOMPANIED BY:

JAMES PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF
MENTAL HEALTH

JOHN D. MAHONEY, BUDGET OFFICER OF THE PUBLIC HEALTH
SERVICE

TONY ITTALAG, DEPUTY ASSISTANT SECRETARY FOR BUDGET,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MIKE ENGLISH, ACTING BUDGET OFFICER, ST. ELIZABETHS HOSPITAL

SUBCOMMITTEE PROCEDURE

Senator SPECTER. This hearing of the District of Columbia Subcommittee of the Appropriations Committee will come to order.

The purpose of this hearing is to inquire into the financing of the St. Elizabeths Hospital. The matter has been one of great concern to the District of Columbia and to the Appropriations Committee.

There has been a request for a cap on the contributions to be made and it is a matter to be in conference between the House committee and the Senate committee, and in order to get a full exploration of the issues and an understanding, we thought this would be an appropriate occasion to do so.

We have observed the reports of the possibility of layoffs at St. Elizabeths Hospital and there was a question as to the appropriation of the committee through the Labor, Health and Human Services Subcommittee which has yet been undetermined but we want to

proceed at this point to get as much information as we can to guide us on these subjects with the House and to assist us in determining what the future will be of this very important installation.

Our first witness is Dr. William Mayer, Administrator of the Alcohol, Drug Abuse and Mental Health Administration.

Welcome, Dr. Mayer.

If you would identify those people who are with you, I would appreciate it.

PREPARED STATEMENT

Your full statement has been received and will be made a part of the record, and in accordance with our customary practice, we would prefer if you could summarize, leaving the maximum amount of time for questions.

[The statement follows:]

STATEMENT OF DR. WILLIAM E. MAYER

I am here today to present the Administration's position on the future of Saint Elizabeths Hospital and to discuss problems associated with the hospital's FY 1984 budget.

Soon after I came to the Alcohol, Drug Abuse, and Mental Health Administration two years ago, I began to review many issues surrounding the operation of Saint Elizabeths Hospital. I was impressed with its rich history as a pioneering mental hospital and the fine work of its dedicated staff. I was concerned, however, about what seemed to be the inordinate size of the facility in light of its steadily decreasing number of resident patients and the population it is designed to serve. The issue I saw was how to reconfigure the hospital's programs to bring them in line with proposals to transfer it to a new form of governance, a corporation more reflective of local needs and the desire of the community, while at the same time protecting quality of care.

It is fair to say that--even though officials have grappled with the same issues for over two decades--I have personally spent more time at the hospital and devoted more time to reviewing its activities than any ADAMHA Administrator. As a result, I have become convinced that the hospital must be reduced in size and scope of programs without harm to the quality of care for those patients who are appropriately a responsibility of the hospital. We have consistently pursued the concept of the corporation to provide greater flexibility in program design and management than could be achieved in an organizational unit of the Federal Government. Many of my views are shared by a team of the General Accounting Office that is studying mechanisms for transferring the hospital to the community. Our position is likewise consistent with a court order which requires the hospital and the District Government to provide the most appropriate care for patients in the least restrictive environment.

I established an Executive Working Group of hospital and ADAMHA officials to identify programs and activities for reorganization, modification, or indeed, elimination to streamline and improve hospital operations, and to focus on the

care that a modern inpatient psychiatric facility should provide. We believe that good clinical and program management call for such changes regardless of the hospital's budgetary situation. In light of the budgetary dilemma facing the hospital in FY 1984, the changes become essential. As we develop specific proposals to streamline hospital operations it will be necessary to reduce staffing levels through reductions-in-force as well as reduce program activities. However, we would prefer to carry out these changes through an orderly management process rather than to meet a short-term budget crisis.

As part of this management initiative, I have reopened discussions with the District of Columbia for transferring both fiscal and management responsibility for the hospital. We have arrived at a mutually agreed upon set of objectives leading to the transfer and have begun to identify programs at the hospital which may be reduced or perhaps eliminated. The primary function of Saint Elizabeths is to provide inpatient psychiatric hospital care as one part of a larger mental health system. We have found many functions which take place in the hospital that could be provided more efficiently and effectively in other settings in the community. These are undeniably good and important parts of a total health care system but need not take place within the hospital proper.

For example, the hospital's Medical Surgical and Support Program provides physical-medical care not only for Saint Elizabeths inpatients but for some of its outpatients as well. We believe that the District of Columbia's Government could be providing the medical services as part of its responsibility to serve needy D.C. residents. Saint Elizabeths Hospital also provides alcoholism and drug abuse services not ordinarily provided in a public mental health institution.

Patients under treatment for alcohol and drug abuse only should be receiving services in programs operated by the District of Columbia--special programs which should include both residential and outpatient treatment similar to that now provided by Saint Elizabeths but at far lower cost and in a less restrictive environment.

In addition to these programs which more appropriately should be provided by the community, there are others which Saint Elizabeths need not be required to sustain. For example, the hospital operates extensive training programs in psychiatry, psychology, nursing, social work, the chaplaincy, and specialized therapies which are excellent and known nationally but which the District of Columbia may wish to reduce or may not wish to maintain since it has no real obligation to conduct these.

Reduction in the size of the hospital not only will require that some services be made available elsewhere in the District but also that some patients be moved. Many patients, whose physical and psychiatric conditions do not warrant their being housed in a mental institution, could and should be transferred to nursing homes or other community settings. Because both we and the District Government share humane concerns for the welfare of the patients, we are moving ahead to locate the necessary community resources and services for these patients now at Saint Elizabeths.

If adequate community mental health services were available, about 1300 Saint Elizabeths outpatients could be removed from the rolls right now. If there were both proper care and affordable housing for independent living and in community residential facilities, increasing numbers of inpatients could leave the hospital. If more nursing beds were available, 125 more inpatients would be able to leave. There are yet other patients who need residential psychiatric rehabilitative care--not necessarily in a hospital setting--who could leave the hospital if community resources were made available for their needs.

Needed programs in the community and the needed housing do not exist at present and will not appear overnight. Thus, we must face the prospect that a sudden budget reduction of the magnitude which now faces the hospital--\$25 million--can have an effect on the patients, the staff, the hospital, and the community which none of us desires.

It is unfortunate, although understandable, that the budget issue facing us today appears to have distracted public and Congressional interest from the more important and fundamental issue of transferring responsibility for Saint Elizabeths to a corporation that can more readily and effectively respond to the community it serves. As the Washington Post editorial of July 29 urges, "...however this year's budget comes out, negotiations over an eventual transfer of Saint Elizabeths from the Federal Government to the District--which have been going on for years--should be stepped up." We agree, but a great deal of further discussion with this committee and other committees of the Congress who have a serious interest in the affairs of the District, with D.C. officials, and with hospital and Institute staff must take place before final plans are made for how best to proceed.

Our budget proposals have consistently reflected our goal of a gradual, orderly, but definite assumption by the District of fiscal and management responsibility for hospital operations through the mechanism of a corporation outside the Federal Government. Clearly, a facility that has evolved from a national treatment center to one now serving almost exclusively a local population should be under local management. As observed previously we are not the first Administration to hold this view or to seek a reasonable and equitable way to effect such a transfer of responsibility and authority.

The District again appears willing to move ahead on the transfer of this responsibility. In a recent letter to OMB Director Stockman, Mayor Barry, after expressing his concerns with the corporation proposal, stated that "The District Government accepts its responsibility for mental health services for District residents," and added that there should be "an end of Federal administrative responsibility for Saint Elizabeths Hospital." Over the past several months the Department and the District Government have been engaged in intensive discussions about the transfer.

However, over the past several weeks, actions by the Congress have left the Administration concerned over funds available to continue hospital operations

after October 1. Our budget proposal to the Congress was for \$143.5 million for the hospital in FY 1984 including an ADAMHA subsidy of \$62.7 million. We are asking for no increase in the Federal appropriations. The total hospital budget will require an increase in reimbursement from the District of Columbia from \$24.7 to \$54.5 million. This increase in the D.C. payment was based on the assumption that the District would pay an increased share of costs for those patients who are residents of the District. Today, approximately 90 percent of the patients at Saint Elizabeths are residents of the District; yet in FY 1983 the District will pay only 22 percent of the cost of D.C. resident treatment. By comparison, the District paid 69 percent in 1970 and 37 percent in 1975.

The budget recently passed by the House of Representatives for the District of Columbia, however, would limit the amount of D.C. reimbursements to the hospital to \$29.5 million rather than the \$54.5 million actually required from the District to maintain current operations. In effect, this action reduces the hospital's FY 1984 budget request by \$25 million. Therefore, even though the bill passed by the Senate does not legislate a limit on the District's contribution to Saint Elizabeths, we must continue to work closely with the the District to identify the additional funds and savings needed for the hospital's operation.

Because of the very real possibility that the hospital will be faced with a significant reduction in its operating budget beginning October 1, we asked the Superintendent of Saint Elizabeths, Dr. William Dobbs, and his staff to develop the necessary contingency plans to continue operating the hospital with a very substantial budget shortfall.

Our chief guiding principle in developing these contingency plans is to preserve the quality and availability of the hospital's inpatient psychiatric care. That is what it is primarily designed to provide. We are already moving ahead to lay out a variety of options to meet the eventuality of a reduced operating budget for FY 1984. We wish to assure staff that the hospital has not been ordered to fire employees. The hospital has not been ordered to eliminate

any programs. These are "worst case" considerations we hope will not be necessary to act upon. But, I must report to you, Mr. Chairman, that if the District's payment to the hospital cannot be adjusted to the required level, then sizeable staff cuts and program reductions will have to be made to preserve the most critical patient services. That is why the hospital has been asked to identify those vital programs that must not be modified and those that with minimum disruption to the quality of overall care might be reduced or eliminated. Given the nature of hospital care, the usual across-the-board reductions are not appropriate. We would instead close down any hospital services that duplicate others available elsewhere, or not ordinarily carried on in a large public mental health institution.

I hope I have made clear that the Administration has no intention of hurting patients or of dumping responsibility for Saint Elizabeths Hospital on the District of Columbia. Our hospital management initiative is intended to provide an incentive for the District to take over responsibility for a lean and well functioning hospital. Our planned 10 year phase down of Federal funding, coupled with appropriate deinstitutionalization of patients, reflects our commitment to help maintain necessary levels of care at the institution, and to safeguard the hospital's accreditation.

Our budget request for FY 1984 explicitly asks that the District Government pay the cost of patients who should be in nursing homes. We hope that the incentive of saving money as well as providing care in more appropriate and less restrictive settings will encourage the District to make greater efforts to assist us in reducing the size of the hospital population.

Should we be required to move more swiftly than planned to streamline hospital operations in response to a severe budget shortfall, the Administration will do everything in its power to meet the immediate demands without losing sight of the long-range goal of helping the District to define the hospital's ultimate role in its comprehensive, community-wide mental health care system.

... Chairman, the transfer of these responsibilities is indeed a complicated task. However, we stand willing to work cooperatively with the Congress and the District to ensure that this community's residents receive quality mental health care.

My staff and I shall be pleased to respond to any questions you may have.

INTRODUCTION OF ASSOCIATES

Dr. MAYER. I am accompanied by James Pittman who is Executive Officer of the National Institute of Mental Health. On his left is Mr. John D. Mahoney, the Budget Officer of the Public Health Service. On the far right is Tony Ittalag who is Deputy Assistant Secretary for Budget in the Department of Health and Human Services. And on my immediate right, Mr. Mike English, the acting budget officer from St. Elizabeths Hospital.

First, I want to thank you for this opportunity. I think it is time that we made very clear what we individually in Health and Human Services, along with the people in the District and the staff at the hospital, are trying to do at that great institution.

I realize that reading my statement would be somewhat out of keeping with your usual practice but I have tried to make it as concise as possible and tried to include in it the bulk of things that enter into this enormously complex situation.

Senator SPECTER. If you would find it necessary to read your statement, you may proceed as you choose.

Dr. MAYER. Thank you, sir

FUTURE OF ST. ELIZABETHS HOSPITAL

I am here today to present the Administration's position on the future of St. Elizabeths Hospital and to discuss problems associated with the hospital's fiscal year 1984 budget.

Soon after I came to the Alcohol, Drug Abuse, and Mental Health Administration 2 years ago, I began to review many issues surrounding the operation of St. Elizabeths Hospital. I was impressed with its rich history as a pioneering mental hospital and the fine work of its dedicated staff. I was concerned, however, about what seemed to be the inordinate size of the facility in light of its steadily decreasing number of resident patients and the population it is designed to serve.

Throughout the country there are 45 to 100 beds publicly funded for every 1,000 of population. At St. Elizabeths, we are operating 300 beds per 1,000.

The issue I saw was how to reconfigure the hospital's programs to bring them in line with proposals to transfer it to a new form of governance, a corporation more reflective of local needs and the desire of the community, while at the same time protecting quality of care. This is in keeping with the basic principles of community mental health in this country for the last 100 years.

I think it is fair to say, even though people have been grappling over the issue of what to do with St. Elizabeths for about 20 years, but I have probably spent more time personally at that hospital than anyone else who has been responsible for it in recent years. The reason is I have been in community mental health throughout most of my career. I was the State Mental Health Commissioner in California during a time of reduction in State hospital services, an increase in local services, and St. Elizabeths presented both problems and opportunities for doing something really quite fine as a model for the rest of the country.

I had become convinced that the hospital will probably have to be reduced in size, that it is inordinately expensive because of its size, and that the scope of programs may have to be reduced in order to maintain a high level of quality of care for those patients for whom there are no alternative treatments or facilities.

We have consistently pursued this concept of a corporation in order to provide greater flexibility in program design and management that can be achieved in an organizational unit of the Federal Government.

I believe many of my views are shared by a team from the General Accounting Office who have been studying the situation at St. Elizabeths and who have conferred with us repeatedly.

Our position and what to do with the hospital is also consistent with a court order which requires the hospital and the District government to provide the most appropriate care for patients in the least restrictive setting, which is the goal throughout the country, of course.

I therefore established an executive working group of hospital and ADAMHA officials to identify those programs and activities that might be modified or, if appropriate, to eliminate in order to streamline and improve the hospital operation and to focus on the care that a modern inpatient psychiatric hospital should give.

We believe that good clinical and program management call for such changes regardless of the hospital's budgetary situation.

In light of the budgetary dilemma facing the hospital in fiscal 1984, the changes become even more pressing and indeed essential. As we develop specific proposals to streamline hospital operations, it may become necessary to reduce staffing levels through such mechanisms as reductions in force, as well as reduced program activities.

However, we prefer to carry out these kinds of changes through an orderly management process, working closely with the District government, rather than to try to push them through hurriedly to meet a short-term budget crisis.

As part of this management initiative, I have reopened discussions with the District government for transferring ultimately both fiscal and management responsibility for the hospital. We have arrived at what I think are clearly and mutually agreed upon set of objectives and have begun to identify programs at the hospital which may be reduced or eliminated or changed in some way.

OBJECTIVES FOR ST. ELIZABETHS

The primary function of St. Elizabeths after all is to provide inpatient bed type psychiatric hospital care as part of a much larger and more comprehensive and more complex mental health system. We found many functions which take place in the hospital that could be provided both more efficiently and more effectively outside the hospital, in community settings which would be appropriate and more realistic.

These are undoubtedly very good and important parts of the total health care system but they do not need to take place within the confines of an expensive, 24-hour-a-day hospital. For example, the hospital's medical and surgical and support program provides physical, medical care. Not only for St. Elizabeths inpatients but also some of its outpatients as well.

We find many patients who, in years past, were patients at St. Elizabeths, have been discharged, go out, they develop a physical problem, they are quite likely to come back to St. Elizabeths. That is a measure of their devotion, but it is an inappropriate way to use a psychiatric hospital.

We believe that the District government could be providing the medical services as part of its responsibility to serve the need among D.C. residents.

St. Elizabeths also provides a drug and an alcohol program which duplicates in some ways that provided by the District itself. Alcoholism and drug abuse services in the absence of mental disease, and most alcoholics and drug abusers are certainly not mentally ill, are not ordinarily provided in a public mental health full-time hospital. Patients under treatment for those disorders, and only for those disorders, should be taken care of in programs operated by the District.

In addition to these programs, which more appropriately should be provided by the community, there are others which St. Elizabeths need not be required to sustain. For example, the hospital operates extensive training programs in psychiatry, psychology, nursing, social work, the chaplaincy, and specialized therapies which are excellent, and they are known nationally, but they are programs which the District of Columbia is under no obligation to conduct and should not be required to do so unless they choose to do so under some kind of a system which reimburses them adequately for that.

A reduction in the size of the hospital, which is going to be necessary just on a professional programmatic standpoint, regardless of budget considerations, will require that some services be made available elsewhere in the District. It may also require that some patients be moved when their physical and psychiatric conditions do not warrant their being housed in a mental hospital. Some of these should and could be transferred to nursing homes or community settings.

Both we and the District government share human concerns for the welfare of these patients. Because of that, we are moving ahead to try to locate, where possible, the necessary community resources and services for these patients who are now inappropriately at St. Elizabeths. If adequate community mental health services were available, of the kind

that are available in many other States and large cities, about 1,300 St. Elizabeths outpatients could be removed from the rolls right now. If there were both proper care and affordable housing for independent living and in community residential facilities, increasing numbers of inpatients could leave the hospital. If there were more nursing beds available in the community, at least 125 more inpatients could leave the hospital right away.

There are yet other patients who need residential psychiatric rehabilitation services but not necessarily provided in a hospital setting. They could leave the hospital.

Needed programs in the community and needed housing for patients who could utilize such programs do not exist at the present time and will not appear overnight.

Thus we must face the prospect of a sudden budget reduction of the magnitude which now faces the hospital, \$25 million, can have an effect on the patients, the staff, the hospital, and the community, which none of us desire.

It is unfortunate, although understandable, that the budget issues appears to have distracted public and congressional interest from the more important and more fundamental issue of transferring responsibility from St. Elizabeths to a corporation that can more readily and more effectively respond to this community which it serves.

As the Washington Post editorial on the day following the initial front page article, an editorial of June 9 urges, and I quote:

However this year's budget comes out, negotiations over an eventual transfer of St. Elizabeths from the Federal Government to the District, which has been going on for years, should be stepped up.

We agree, but a great deal of further discussion with this committee, with other committees of the Congress who have a serious interest in the affairs of the District, further discussion with D.C. officials and with hospital and institute staff must take place before final plans are made on how best to proceed.

TRANSFER OF FISCAL AND MANAGEMENT RESPONSIBILITIES

Our budget proposals have consistently reflected our goal of gradual and orderly but definite assumption by the District of fiscal and management responsibility for hospital operations through the mechanism of a corporation outside the Federal Government.

Clearly, a facility that has evolved from a national treatment center to one now serving almost exclusively a local population should be under local management.

As observed previously, we are not the first Administration to hold this view or to seek a reasonable or equitable way to effect such a transfer of both responsibility and authority.

The District again appears willing to move ahead on the transfer of this authority. In a recent letter to OMB Director Stockman, Mayor Barry, after expressing his concern with the corporation proposal in its present form, stated, "The District government accepts its responsibility for mental health services for District residents," and he added, and I

quote again, "and end of Federal administrative responsibility for St. Elizabeths Hospital."

I do not infer from that statement that there is any time that the Mayor has in mind but simply philosophically he agrees in principle with this.

Over the past several months, the Department and the District government have been engaged in intensive discussion. However, over the past several weeks, actions by the Congress have left the Administration concerned over funds left to continue operations after October 1. Our budget proposal to the Congress was for \$143.5 million to operate the hospital in fiscal year 1984, including an ADAMHA subsidy of \$62.7 million. We are asking for no increase in Federal appropriations. The total hospital budget will require an increase in reimbursement from the District of Columbia from \$24.7 to \$54.5 million. This increase in the D.C. payment was based on the assumption that the District would pay an increased share of the cost for those patients who are residents of the District.

Today, approximately 90 percent of the patients at St. Elizabeths, by our reckoning, are residents of the District of Columbia. Yet, in fiscal year 1983, the District will pay only 22 percent of the cost of the hospital.

By comparison, the District paid 69 percent of the cost in 1970, and that had dropped to 37 percent in 1975, because a cap was imposed by the Congress on the amount that the District would contribute.

The budget recently passed by the House of Representatives for the District of Columbia would limit the amount of D.C. reimbursements to the hospital to \$29.5 million rather than the \$54.5 million actually required from the District to maintain current operations.

In effect, this action reduces the hospital's 1984 budget request by \$25 million. Therefore, even though the bill passed by the Senate does not legislate a limit on the District's contribution to St. Elizabeths, we must continue to work closely with the District to identify both the additional funds and savings needed for the hospital's operation.

Because of the very real possibility that the hospital could be faced with a significant reduction in its operating budget beginning October 1, we asked the superintendent of St. Elizabeths, Dr. William Dobbs, and his staff to develop the necessary contingency plans to continue operating the hospital with a very substantial budget shortfall.

Our chief guiding principle in developing these contingency plans is to preserve the quality and the availability of the hospital's inpatient psychiatric care. That is what it is primarily designed to provide. We are already moving ahead to lay out a variety of options to meet the eventuality of a reduced operating budget for 1984, which begins in less than 2 months.

NEED FOR STAFF CUTS AND PROGRAM REDUCTIONS

We wish to assure the staff that the hospital has not been ordered to fire employees. The hospital has not been ordered to eliminate any programs. These are worst case considerations we hope will not be necessary to act upon.

But I must report to you, Mr. Chairman, that if the District's payment to the hospital cannot be adjusted to the required level, then sizable staff cuts and program reductions will have to be made to preserve the most critical patient services which we cannot let go of by an order of the court. This is why the hospital has been asked to identify the most vital programs which must not be modified and those with minimum disruption to the overall care might be reduced or transferred elsewhere.

Given the nature of hospital care, the usual across-the-board reductions are simply not appropriate. We would instead close down any hospital service that duplicates others that are available elsewhere or are ordinarily not carried on in a large public psychiatric institution.

I hope I have made clear that the administration has no intention of hurting patients or of dumping responsibility for St. Elizabeths Hospital on the District of Columbia.

Our hospital management initiative is intended to provide an incentive for the District to take over responsibility for what should become a lean and well-functioning hospital. Our planned 10-year phasedown of Federal funding, coupled with appropriate deinstitutionalization of patients, reflects our commitment to help maintain necessary levels of care at the institution and to safeguard the hospital's accreditation which is a matter of great importance.

Our budget request for fiscal year 1984 explicitly asks that the District government pay the cost of patients who should be in nursing homes. We hope that the incentive of saving money, as well as providing care in more appropriate and least restrictive settings, will encourage the District in helping us reduce the size of the hospital population.

Should we be required to move more swiftly than planned to streamline hospital operations in response to a budget shortfall, the administration will do everything in its power to meet the immediate demands without losing sight of the long-range goal of helping the District to define the hospital's ultimate role in a comprehensive communitywide mental health care system.

Mr. Chairman, the transfer of these responsibilities is indeed an enormously complicated task. However, we stand willing to work cooperatively with the Congress and the District government to insure that this community's residents receive quality mental health care.

My staff and I would be very happy to answer your questions.

TREATMENT FOR DRUG ABUSERS

Senator SPECTER. Doctor, you have referred to the possibility of reducing treatment for drug abusers, and it raises a very important consideration on a problem which has many aspects, one of which is the medical treatment for the drug abuser.

Another aspect is for community safety because the drug users are a problem on crime control and a burden to the courts; and it has many interrelated aspects, most fundamentally one of public safety from the possibility of robberies and burglaries and other crimes of violence by drug users.

My question is, If there is a phasedown on what St. Elizabeths will do for the drug users, are there other facilities adequate in the District of Columbia to take care of these people?

Dr. MAYER. The adequacy of other facilities and programs in the District of Columbia to take care of those drug abusers which are presently hospitalized at St. Elizabeths is a matter of some conjecture, and I am sure some argument is possible.

However, it has to be pointed out that except for those people who are judicially committed to St. Elizabeths, the people receiving drug abuse treatment there do not differ in any significant way from the great majority of drug abuse patients throughout the country who are not best treated in inpatient facilities but in a variety of outpatient day treatment facilities and treatment centers.

We are concerned with the fact that the primary mission of the hospital is the psychiatric hospitalization of mentally ill persons—

Senator SPECTER. That may all be true but, at the present time, there are a certain number of drug users that are being treated at St. Elizabeths.

What is your worst case scenario as to how many of those might be excluded from treatment and where are they going to go?

Mr. ENGLISH. We have 29 inpatient facilities and 10 outpatient being served by that drug program. Of the 29, there is no specific program that we have identified that is available for those patients. But there are outpatient facilities available in the District of Columbia for that.

Senator SPECTER. Do we have your assurance that before you oust these people, there would be some alternative program or placement to be accomplished prior to the time that they no longer receive care from St. Elizabeths?

Dr. MAYER. We would certainly make every effort to do that. As far as being able to guarantee that, I am not sure that I can.

Senator SPECTER. So that we may be faced with a situation where the drug treatment would be phased out of St. Elizabeths without having adequate alternatives to place people in?

Dr. MAYER. That would be a matter for the District of Columbia to decide.

Senator SPECTER. What you are saying is St. Elizabeths could not continue that responsibility and then it would be up to the District to solve the problem?

Dr. MAYER. Yes.

AVAILABILITY OF NURSING HOMES

Senator SPECTER. Where you make a reference here to the aspect of transferring some of these people to nursing homes or other community settings, here again the question arises, are there nursing homes or other community settings which would be available to take these people?

Dr. MAYER. There are some, not enough, which has been our problem. There have not been available beds in skilled nursing facilities in the District to absorb the patients who are ready to go to such facilities.

Senator SPECTER. Dr. Mayer, this comes up in quite a number of spots in your testimony. I only picked out the drug users and the community settings as two which are illustrative. It is obviously a major problem. If St. Elizabeths is not going to continue to serve these people, then the issue is are there other facilities available.

You have said that you cannot guarantee that St. Elizabeths will continue to serve the people, even if other facilities are not available.

Now, later on in your statement—

Dr. MAYER. That only applies, however, to the drug abusers. That is not true of the nursing home patients. We could never put those out with no facility to accept them.

Senator SPECTER. Is there any other category besides the drug users whom you would not exclude from St. Elizabeths Hospital without being sure that there were other facilities available for them?

Dr. MAYER. Anyone who is acutely psychiatrically ill, profoundly disabled, unable to care for themselves. We are not going to put people like that out on the street.

Senator SPECTER. Is there any category which would be excluded from St. Elizabeths without being sure that the District had alternative facilities available?

Dr. MAYER. There is no such category that can be established at this point without much more exhaustive discussions with the District and with the staff of the hospital and the staff of other facilities.

SHIFTING RESPONSIBILITY FOR CARE OF PATIENTS

Senator SPECTER. You say on page 9:

I hope I have made clear that the Administration has no intention of hurting patients or of dumping responsibility for St. Elizabeths Hospital on the District of Columbia.

That is a fine generalization, but in order to make good on that assurance, you have to be in a position to say that St. Elizabeths will not give up its current responsibilities in the absence of alternative care.

Now, maybe you cannot. Either you can or you cannot. But if you cannot, then you really are placing the responsibility on the District of Columbia. I am not going to use your word "dumping." That is a harsh word. That is the word you have chosen.

But the committee would like to understand just what your position is. Either you are going to shift the purpose to the District or you are going to maintain the facilities at St. Elizabeths, as they are now, unless there are other adequate facilities in place before you cut back at St. Elizabeths, and the point of the inquiry is, what is your position?

Dr. MAYER. We are not going to be abruptly shifting responsibility for care of patients who are appropriately in a mental hospital, which may not include all of the patients who are currently at St. Elizabeths. St. Elizabeths is a hospital. It is not a hospice or a residential care facility. It costs the people of the United States, as well as the people of the District, several hundred dollars a day for many patients who are there who, by no stretch of the imagination, should be hospitalized in a mental hospital. That does not mean we will take them to the gate and drop them off.

Senator SPECTER. You say you are not a residential care facility and you are not a hospice.

Now, the question is, If there are people in St. Elizabeths who ought to be in a residential care facility or in a hospice, will you be sure that those facilities are available before you exclude those people from St. Elizabeths?

Dr. MAYER. We feel morally bound to take care of the patients that are there, yes, sir.

Senator SPECTER. You say that:

We wish to assure staff that the hospital has not been ordered to fire employees. The hospital has not been ordered to eliminate any programs.

Then you say:

These are worst case considerations we hope will not be necessary to act upon. But I must report to you, Mr. Chairman, that if the District's payment to the hospital cannot be adjusted to the required level, then sizable staff cuts and program reductions will have to be made to preserve the most critical patient services.

Well, as you articulated here on what you say is the worst case, what is the worst case as to what you say are sizable staff cuts and program reductions?

REDUCTION IN FORCE OF 653 PEOPLE

Dr. MAYER. The worst case is what we specified to the hospital; namely that it would take, in order to stay within a \$25 million shortfall——

Senator SPECTER. What is that?

Dr. MAYER. A reduction in force of probably approximately 653 people. We would also——

Senator SPECTER. If you reduce the force by 653 people, will you be cutting in areas where there are alternative sources of care or will you be cutting in areas where there are not alternative sources of care; and if the District cannot find them, then the people who are currently being served will not be served by anyone?

Dr. MAYER. The reason that we are engaged in very intensive planning, both with the District and with the hospital staff, is to make sure that nobody is simply denied care altogether. If we reduce the hospital staff by the number we suggested, which is dictated by the amount of money that just is not there, then it will require that we consolidate some divisions, combine some divisions, reduce some of the maintenance activities, reduce some of the housekeeping activities, but it will not result in patients who are presently there not receiving treatment. That would be irresponsible. We are running a hospital——

Senator SPECTER. So you can reduce 653 employees and not eliminate care for patients who are now receiving treatment?

Dr. MAYER. We are trying to devise a system for doing that and we believe it will be possible. It will not be easily possible.

Senator SPECTER. I would like to ask you what your worst case scenario was if you reduced the 653 employees, how many patients will be affected, but you are saying none.

Dr. MAYER. I am saying possibly all will have to be affected by having to reduce the level of care we are now able to give with that many employees. When we reduce——

Senator SPECTER. What is the total number of employees now?

Dr. MAYER. About 3,900.

Senator SPECTER. So out of 4,000 or so, you are cutting 650 for about a 15- or 16-percent reduction.

Dr. MAYER. Yes, sir. But it must be remembered that most of those are not direct patient care, they do not deliver services directly to patients. They are maintenance and support people. It will require, in the estimate of the hospital staff, that some professionals do their own clerical supportive work, which would be an inefficient way to operate, but we believe it could be done.

SETTING UP A CORPORATION

Senator SPECTER. When you talk about a corporation, what do you anticipate this corporation to do? This is going to be a holding company, a nonprofit holding company. There is no magic that setting up a corporation will accomplish that will satisfy some of these funding problems.

Dr. MAYER. We believe a corporation will have somewhat more flexibility in designing programs—a corporation is not just supposed to be—what we propose is not supposed to be responsible solely for the hospital but for a whole mental health system that would serve the District, of which the hospital is just one part.

So the corporation would have flexibility to make modifications in programs that seem appropriate. For example, contracting out the medical-surgical support system program, arranging for acute psychiatric care, for example, at another hospital rather than within St. Elizabeths, emergency-type care—

Senator SPECTER. Dr. Mayer, when you make this projection of cutting 653 positions as a worst case scenario, would that projection be affected by a somewhat larger budget that might be granted by the Congress? The Labor, Health and Human Services Subcommittee, for example, in the Appropriations Committee, I am on that committee, has not even had a markup. What level of appropriations are you considering which would require a 653-person reduction? You might get more money than you are looking for, which would eliminate this problem.

Dr. MAYER. Of course.

Obviously, as a public servant responsible for the disbursement of public funds, I cannot wait until I run out of money before I plan for what we will do if we do not get it; and what appears so far, we will be \$25 million short. We need \$143.5 million for fiscal year 1984. Our whole position is simply that the District should pay a larger share of the cost that begins to approach its share of the burden of operating the hospital. So that our plan simply calls for their contribution to be raised.

I am not here to ask the Congress for more money in our budget. We are still paying far more than one-half the cost of operating that hospital and it is only taking 7 to 10 percent of the people who are our responsibility.

Senator SPECTER. Dr. Mayer, thank you very much. Your testimony is very helpful. We will continue to work with you.

I know that the Labor, Health and Human Services Subcommittee will be very much concerned with the issue on markup of that subcommittee and perhaps there will be something that can be directed to the problem. I do not know. I am making no commitment but I think there is that possibility.

Dr. MAYER. Thank you very much. It is very important that we work together with the Congress, the committees that are involved with the District, because it has a very great need. We do not want to do any harm to anyone and we believe that by working jointly together, and not being driven solely by the budget numbers, but by looking at the program which is where we have to start, turn that into the kind of hospital that can serve as a model for the whole country. That is our desire.

Senator SPECTER. Thank you very much, Dr. Mayer.

DISTRICT OF COLUMBIA

EXECUTIVE OFFICE OF THE MAYOR

STATEMENT OF GLADYS MACK, DIRECTOR, OFFICE OF POLICY AND
PROGRAM EVALUATION, EXECUTIVE OFFICE OF THE MAYOR

INTRODUCTION OF WITNESS

Senator SPECTER. I would like now to call Ms. Gladys Mack, the Director of the Office of Policy and Program Evaluation of the Executive Office of the Mayor.

We thank you for joining us.

Do you have a prepared text to give us?

PREPARED STATEMENT

Ms. MACK. I have a prepared statement. I would like to summarize the major points.

Senator SPECTER. We have not received a copy, and if you would make a copy available to us, we will place a copy in the record.

[The statement follows:]

STATEMENT OF GLADYS W. MACK

I am Gladys W. Mack, Director of the Office of Policy and Program Evaluation, and I am pleased to be here this morning to speak on behalf of the District Government about issues related to St. Elizabeths Hospital.

I want to begin by recounting some of the Hospital's history, and then describe our current efforts to develop a mutually acceptable plan for the future of St. Elizabeths.

BACKGROUND

For more than one hundred years St. Elizabeths Hospital has been the largest federal hospital in the nation devoted entirely to the care of the mentally ill. It was established by Congress to provide "the most humane care and an enlightened curative treatment of the insane of the Army and Navy of the United States and of the District of Columbia". The first patients were admitted in 1855.

Current patients include beneficiaries of the Veterans Administration, the U. S. Soldiers Home, and the Public Health Services; non-residents of the District of Columbia found to be mentally ill while in the District; residents of the Virgin Islands and the Canal Zone; certain mentally ill persons charged with or convicted of crimes in the District; patients committed under court order by federal courts outside the District; those found "not guilty by reason of insanity" in federal courts; citizens of the United States without state residence who become mentally ill while abroad; and patients who participate in a national program for the deaf. Recently the U. S. Immigration and Naturalization Service arranged to lease facilities from St. Elizabeths to house Cuban refugees who are being detained.

During much of its history, St. Elizabeths has enjoyed an international reputation as a leading psychiatric institution.

Many new means of patient treatment were either pioneered here, or adopted very early after introduction elsewhere.

In addition, St. Elizabeths has increasingly served as the major inpatient mental health hospital for indigent District residents, and one of three community outpatient care centers.

STUDIES OF ORGANIZATION AND GOVERNANCE

For nearly two decades the administrative and financial structure of SEH has been debated by local and federal officials and national leadership. The Jones Committee, appointed by HEW Secretary Anthony Celebrezze in 1963, proposed that SEH be operated as a national demonstration center under NIMH. That proposal was carried out in 1968 by Secretary John Gardner.

In 1970, HEW formed the Rome Committee, whose members recommended the transfer of SEH to an independent mental health authority. In 1977, the House District Committee chaired by Congressman Diggs proposed combining the operation of SEH and the District's public mental health services. Neither of these proposals was implemented. HEW Secretary Joseph Califano established a St. Elizabeths initiative to bring the Hospital up to nationally recognized standards. This group pursued the idea of a public corporation to administer St. Elizabeths, and a joint HHS/District task force worked throughout 1980 to try to reach agreement. Although many aspects of the plan were mutually acceptable, some issues remained unresolved.

Early in 1982, the House District Committee requested the GAO to undertake an analysis and to make governance and financing recommendations on the future of the Hospital. Their report is due this fall. Our expectations are that this study will provide an important set of data, such as patient admission trends, long term care trends, capacity of various system

components, alternative uses of physical plant, and cost projections.

The reason that so many well-informed and well-motivated groups have had difficulty in resolving the future of St. Elizabeths is that the problem is exceedingly complex. This federal institution grew to a large size over the years as a national hospital, but one delivering local services. Because of its distinctive federal interest and role, and its location in the nation's capital, it has developed very differently from a traditional state mental hospital.

For these reasons, there can be no "quick fix" to the problem. Detailed planning and staging, in advance, is essential to any change.

We continue to urge the federal government not to abandon the service, training and research programs which have made this Hospital so exceptional and unique over the last century. At the same time, however, we recognize that we must define more clearly the size and cost of a mental health care system more appropriate to the needs of our citizens.

We have participated actively in the relief of fiscal pressures associated with the Hospital's current budget problems:

- * Over the last two years the District will have increased its contribution to the SEH budget 41 percent, from \$20 million in 1982 to \$29.5 million in 1984.
- * The District has doubled its contribution to the capital debt service of the Hospital during the same period; the annual total is now \$2.8 million.
- * The District has signed a Medicaid inpatient and outpatient provider agreement with the Hospital in order that the

eligible patients can be billed through this system, thus increasing potential Hospital revenues by \$14 million in the current year.

- * During 1983 and 1984 the District, through its state planning mechanisms, has authorized the expansion of our long term care system by more than 800 beds, which will increase Medicaid costs by nearly \$22 million. This will make possible additional progress in meeting Dixon deinstitutionalization commitments.

By taking all these steps we have demonstrated our strong commitment to our Dixon obligations, and our willingness to undertake a larger share of the costs of inpatient mental health costs at St. Elizabeths. We should not, however, be required to go further without a systematic, equitable and detailed plan for the future of St. Elizabeths.

Such a plan requires two things: first, it must be based on hard data about patient profiles and projections, and about operating and capital costs. Second, it must be developed in a planning framework which assures a comprehensive and equitable outcome.

We are working diligently to prepare such a plan. We expect that the ADAMHA Executive Working Group chaired by Dr. William Mayer will produce a substantial amount of the necessary information. We also expect to take full advantage of the report of the GAO audit group.

We are still seeking two additional and essential pieces of information: an independent fiscal audit, in order to avoid the possibility of any hidden costs or liabilities within the Hospital operation, and an independent engineering audit, to quantify the true costs of bringing each of the more than

100 buildings on the campus up to the standards required by safety codes, treatment standards, and the obligations of historic preservation.

We will also continue to seek the necessary framework to produce an acceptable plan. In May of this year, Mayor Barry proposed to the federal government that it recognize the interdependence of federal and local responsibility, and the resulting complexity of this issue, by joining in the creation of an independent, impartial body to oversee the production of a long range plan.

In the absence of a response, we intend to continue to work on our own. We feel strongly, however, that an objective process is required, so that both national and local interests can be protected, and so that the outcome will be a successful one.

OPENING REMARKS

Ms. MACK. I am Gladys Mack, Director of the Office of Policy for the District of Columbia, and I am pleased to be here this morning on behalf of the District government to discuss issues——

Senator SPECTER. We have had distribution to the media. Could we have distribution to the committee?

Ms. MACK. I want to talk a little bit about the history of the District's involvement with the hospital and then talk about the current situation and some of our recommendations.

Much of the history has already been pointed to by Dr. Mayer. The hospital is over 100 years old. The current patients who are in the hospital are beneficiaries of the Veterans Administration, U.S. Soldiers Home, the Public Health Service, and residents of the District of Columbia. There are also residents of the Virgin Islands, the Canal Zone, and other wards of the U.S. Government, including a 300-bed facility for those who are forensically insane.

There is some discussion about the number of residents in the hospital that are D.C. residents. If you take a look at the admissions in 1982, 21 percent of those admissions were out of State or of unknown address.

The hospital has enjoyed a long tradition as a fine psychiatric institute. It has earned itself an international reputation and has pioneered in many areas of mental health.

The structure and the governance of the hospital have been a subject of some debate over a great number of years, and if you will look at

the history, there have been different bodies and groups that have been set up to study the way in which the District of Columbia could assume more responsibility for the hospital. The latest effort that the District of Columbia was involved in began in 1980 when we had very active discussions and worked out a lot of the steps toward developing a public corporation which would include not only the services of St. Elizabeths Hospital but also the entire mental health program of the District of Columbia.

Those efforts ended in 1982, and the next significant effort toward some change in the relationship in the hospital was initiated in the fiscal year 1983 budget when the Federal Government proposed a financially based transfer of responsibility to the District of Columbia, and I say financially based because that proposal did not consider patient care, the appropriate size of the hospital, the disposition of the facilities, or any consideration of the financial health of the institution.

Subsequent to that budget proposal, the GAO, under the sponsorship of the House District Committee, initiated a study to determine ways in which the governance of the hospital could be changed.

I would like to point out, Senator, that in fiscal year 1983, in response to the budget proposal by the Federal Government, the District took the position that it was inappropriate to make any changes at the hospital based on financial considerations, that those changes should be based on a comprehensive plan that would resolve all issues around the hospital, including finances.

COMPREHENSIVE PLAN FOR ST. ELIZABETHS

Senator SPECTER. Are you undertaking such a comprehensive plan?

Ms. MACK. We have proposed the framework for such a plan. We did that back in May. The Mayor made this proposal to the Office of Management and Budget. We have not received a formal response to that proposal, but subsequent to our request, Dr. Mayer's working group was formed. We are participating with that working group, but it does not represent, in our judgment, the kind of mechanism that we require to insure that the District assumes the proper amount of responsibility in a situation where change of governance of the hospital is completed.

Senator SPECTER. Do you think that comprehensive plan can be ready for operation by fiscal year 1984, which will begin October 1, 1983?

Ms. MACK. Well, again, Senator, we are participating in the plan but we have no control over the decision points in the plan. So I cannot comment on what the mandate is on the Federal Government's side. The factors that we think are important to a plan have not been worked out, and from that point of view, we certainly do not think it can be ready.

I would just reiterate that the concerns that we have for working out a plan would include resolving the issues of those programs that are there because this is a national institution. There are research programs. There are experimental programs. There are residents that are there for national reasons.

NATIONAL PROGRAM OBJECTIVES FOR ST. ELIZABETHS

Senator SPECTER. What is your attitude, speaking for the city, about the aspects of St. Elizabeths which go to those national objectives? Do you feel that they must be maintained?

Ms. MACK. Well, we believe a decision about changing governance of the hospital could indeed include some of those programs that now have a national focus.

Senator SPECTER. What kind of savings would be involved in that?

Ms. MACK. We would assume that if the national programs were continued, that they would be funded by the Federal Government, even though the hospital would be under District control.

Senator SPECTER. So the programs would be continued but it would be separate funding?

Ms. MACK. Yes; at the discretion of the Federal Government.

Senator SPECTER. What kind of dollar figure are we looking toward for those programs?

Ms. MACK. I am not prepared to say what the cost of special programs are at this point. Nor are we prepared today to say what we think the cost of an appropriately sized inpatient mental hospital would be. I think all of that really awaits an analysis of the kinds of patients that are there, and the improvements the facility needs.

Senator SPECTER. That would be a very helpful figure to have by September 12, because there is going to be a markup of the Health and Human Services Subcommittee and, at that time, there could be some action directed to an issue which is national, which you are currently formulating, where that subcommittee makes allocation for a variety of national programs. And this could be one which might be addressed, if it is identifiable as a separate item from what is going on in the District of Columbia. If it is a national program, it might be funded separately.

DEFINITION OF A DISTRICT RESIDENT

Ms. MACK. We could find out the cost of those national programs. However, until we are agreed upon a definition of who is a District resident, we will still have some difficulty determining what the Federal financial responsibility is, and that definition has simply just not been agreed upon between the District and the Federal Government. It is part of an effort that we are undertaking. I indicated to you that the Mayor made a proposal for a study commission in May. We did not get a formal response but we have undertaken our own efforts to arrive at some of the judgments that we think are necessary, and one of those components is the definition of who is a D.C. resident.

Senator SPECTER. What are the considerations on that? What are the points of disagreement or possible disagreement?

Ms. MACK. I do not know the details. I do not know if any of my colleagues can help me.

Ms. REVEAL. There is some ambiguity about a person of unknown address who might be a homeless person, undefined, someone who is picked up at National Airport but has no known address from any other State. That has not been determined. There is considerable com-

plexity about the definition of the forensic patients and which are ours and which are theirs because, you know, there is joint prosecution in many cases and the option to use the District statute to be sure that the person will be incarcerated under the guilty by reason of insanity. So it is those categories, the homeless, the forensics, and the undocumented aliens, that there is some dispute over whether they will be our whole responsibility. The final group is people who are drawn to the District by virtue of the presence of elected and appointed officials who they want to contact and in some way interact with. We think that burden should be shared nationally.

ANALYSIS OF PROGRAMS PROPOSED TO BE CUT

Senator SPECTER. I do not know if you are in a position to comment today. If you are, fine; if you are not, you can provide the information, but the subcommittee would be interested in an analysis of the various categories where there is a proposal that St. Elizabeths would be reduced; as, for example, on drugs or as, for example, on community care or hospices, what facilities there are in the District to accommodate so we can make an evaluation of what is going to happen.

Are you in a position?

Ms. MACK. I am not in a position to comment on that today. We will provide that for the record.

Senator SPECTER. If you could provide that to us, that would be very useful, as early a date as you might. We are going to have a markup. I do not know if we are going to have a—a conference, rather, this week. I had requested one this week and if we do, it would be useful to have it very soon. If not, then you have a little more flexibility.

OVERALL VIEW OF PROPOSAL OF FEDERAL GOVERNMENT

What is your overall reaction, Ms. Mack, to the proposal outlined by Dr. Mayer?

Ms. MACK. We continue to believe quite strongly, Senator Specter, that any change in the funding level for the District or any change in the funding support of the District for St. Elizabeths Hospital has to be based on a comprehensive plan. We recognize the steps that are being taken by the Federal Government as a need to reconcile the level of funding that they now have tentative approval of with their programs. We think that that is a responsibility of the Federal Government and we are not participating in that. We would urge you and your colleagues, if you consider adding funds to the budget of St. Elizabeths, that it get added to the Federal side of the budget because, indeed, that is the side of the budget that is showing a considerably smaller amount of funds in 1984 than there was in 1983.

Senator SPECTER. Thank you very much. We would like you to keep us informed as to the progress of the comprehensive plan.

Essentially what you are saying is you do not know until you have a comprehensive plan and part of that evaluation is going to require knowing what is going to happen to the people for whom services will be cut back.

Please keep us informed.

Ms. MACK. Thank you.

I do want to, though, make sure that you are aware that there are separate planning efforts going on, and although we are working together, it is not assured at this point that those planning efforts will come out in the same place. But we certainly will keep you aware of our own efforts.

Senator SPECTER. Please do because the Congress will have something to say. We may be the umpires.

NONDEPARTMENTAL WITNESSES

MENTAL HEALTH ASSOCIATION OF THE DISTRICT OF COLUMBIA

STATEMENT OF LILLIAN SECUNDY, PRESIDENT, MENTAL HEALTH
ASSOCIATION OF THE DISTRICT OF COLUMBIA

ACCOMPANIED BY:

DR. JULIETTE SIMMONS, PAST PRESIDENT, MENTAL HEALTH
ASSOCIATION OF THE DISTRICT OF COLUMBIA

DR. GOTTLIEB SIMON, BOARD MEMBER

DR. BARBARA I. TOBELMANN, EXECUTIVE DIRECTOR

INTRODUCTION OF WITNESSES

Senator SPECTER. Next we will hear from Mrs. Lillian Secundy, president of the Mental Health Association of the District of Columbia.

Your full statement will be made a part of the record, Mrs. Secundy, and we would appreciate it if you would summarize it.

Mrs. SECUNDY. Senator Specter and members of the subcommittee, I am Lillian Secundy, president of the Mental Health Association of the District of Columbia. Present with me are Dr. Juliette Simmons, past president of the Mental Health Association of the District of Columbia; Dr. Gottlieb Simon, board member, and Dr. Barbara I. Tobelmann, executive director.

The Mental Health Association of the District of Columbia is a United Way Agency and a Division of the National Mental Health Association. We are a nonprofit volunteer organization that has worked since our founding in 1953 to improve the care and treatment of District of Columbia residents afflicted with mental or emotional disorders.

Last week, when Secretary Casper Weinberger learned the Defense Department planned to shoot dogs as part of a research project, he ordered the plan dropped. Now the Department of Health and Human Services is planning to shoot a hospital, St. Elizabeths, and we at the Mental Health Association are hoping that Secretary Margaret Heckler will act as humanely as Secretary Weinberger.

EFFECTS OF CUTBACKS

The Health and Human Services proposal, as you know, would RIF 653 or more St. Elizabeths employees by October 1, cut specialized services, and eliminate whole departments.

Health and Human Services takes an enlightened cost-effective approach in suggesting that whole units be dropped rather than imposing crippling across-the-board cuts. But some of the units they propose to kill are unique to the metropolitan area. The deaf program. The children's program. The Hispanic program. Who will pick up these serv-

ices? Make no mistake, these cuts would be devastating to the patients, to the employees, and the communities who will be asked to absorb additional numbers of people needing inpatient help and additional hundreds of unemployed workers.

A year and a half ago, the Mental Health Association held a public hearing to discuss what would happen if St. Elizabeths budget were sharply cut or the hospital closed as the Office of Management and Budget was then proposing.

We received testimony from the District government, current and former patients, employees, professional associations, churches, and community service facilities and homes. Let me summarize briefly the main themes struck in that testimony and ask that the full proceedings be made a part of today's record.

If Federal money were reduced, local public and private agencies combined could not absorb the additional patients.

A cutback at St. Elizabeths will mean an increase in the homeless who wander the streets and an increase in human misery and social problems.

The idea of precipitously closing St. Elizabeths or cutting back on its services is preposterous, ridiculous, reprehensible, unconscionable, unthinkable, insensitive, absurd, ill-advised and cruel.

The idea of cutting services or closing the hospital has no justification in political philosophy, treatment philosophy, or administrative philosophy; it is a crash attempt to save money for the Federal Government.

The hospital provides vital and beneficial services; nevertheless, in some cases staffing is insufficient. Therefore, instead of reducing funding to the hospital, the Federal Government ought to increase it.

Inasmuch as there are only 380 psychiatric beds in the private sector in the District all total, it is obvious that the District could accommodate only a small percentage of patients forced out, if the cuts were implemented. None of those beds would be for specialized services.

It is equally obvious that the District's budget cannot accommodate a doubling of its budget for St. Elizabeths, as would be required to maintain the level of services if Federal cuts were implemented.

There may be some justification for asking that the District pay more for the support of its patients who are in St. Elizabeths. In fact, the District has increased its payments to the hospital in recent years.

However, there is another issue involved here. Besides asking how much the District will pay to St. Elizabeths, we need to also ask how much of St. Elizabeths budget should be for inpatient services. D.C. patients may require intensive care, but not necessarily institutionalization. The hospital has a role to play in this care. It must be made clear that our support for full funding for the hospital does not mean that we favor a return to inpatient care in place of community care. Perhaps if the Dixon plan for phased deinstitutionalization had been followed according to schedule, today's financial and management panic would not have occurred. But a problem does exist. Congress could ameliorate the situation if it assures continued funding in the short term while pressing both the District and Health and Human Services to carry out their

mutual obligations under the Dixon plan for the long term. The holding of these hearings should be a step in this direction. We are grateful, therefore, to the subcommittee for allowing the Mental Health Association to focus congressional and public attention on this problem, and we thank you for this opportunity to testify on the proposed cuts.

Senator SPECTER. Thank you. The text of the January 18, 1982 community hearing will be inserted in the record.

[The information follows:]

COMMUNITY HEARING ON OMB'S PROPOSAL TO CLOSE OR CURTAIL SERVICES AT ST.
ELIZABETHS HOSPITAL

STATEMENT OF THE MENTAL HEALTH ASSOCIATION
OF THE DISTRICT OF COLUMBIA

The Mental Health Association of the District of Columbia has called these hearings today to provide the community with an opportunity to consider a White House Office of Management and Budget proposal to shut down St. Elizabeths Hospital.

The Mental Health Association is dedicated to improving the well-being of people in the District of Columbia suffering mental and emotional problems, and to promoting effective methods for preventing and minimizing mental disabilities. As an advocacy organization we have followed closely efforts to improve the treatment and to protect the rights of patients at St. Elizabeths Hospital.

St. Elizabeths is the single most important facility for seriously disturbed individuals in the District. It handles approximately 7,800 admissions a year for people needing institutionalization. The private sector, by comparison, profit and non-profit combined, counts about 4,400 admissions a year, half of whom are estimated to be non-residents. On any given day there are approximately 2,100 inpatients at St. Elizabeths while private hospitals average 325 inpatients a day. In addition to its inpatient service, the hospital also carries approximately 3,100 outpatients on its rolls. It is also a major Federal research and training center.

Since St. Elizabeths plays such a pivotal role in providing mental health care, the prospect of closing the institution next October (the start of FY-83) or significantly reducing its funding raises the most serious questions. Where will the patients go who otherwise would be helped by the hospital? Can the District's Mental Health Services Administration pick up this additional demand? Will the private sector -- to which President Reagan daily refers us -- have room for an additional 2,000 patients a day? For 1,000? Or even 500? Can the foster care, half-way houses, or sheltered apartment programs accommodate people who will have nowhere else to go? And how many of these patients will have insurance to pay for their care if somehow room can be found for them?

The proposal to close or curtail services at the hospital comes at a time when the need for its services seems to be increasing. Historical research shows that institutionalization (in prisons as well as in mental institutions) increases following periods of economic hard times. The latest economic indices document that we are now in a recession and that unemployment is once again reaching critical dimensions. Between November 1980 and November 1981 unemployment increased by 14% -- going from 7.9 million to more than 9 million -- and further increases are expected. The proportion of Black youth who are unemployed is of course obscenely enormous. The implications for the District of Columbia need no explication.

The Mental Health Association, therefore, is gravely concerned about this situation. We wonder whether the proposal-makers at the OMB have considered these issues fully in suggesting that St. Elizabeths be "phased out." Instead of reducing funding at St. Elizabeths, we wonder if funding should not be increased in order to meet expected increases in the demand for services.

We hope that these hearings will shed some light on these important questions and provide an opportunity for all interested members of the community to comment. We shall, of course, provide a record of this hearing to the OMB and others in the Administration and Congress who may be involved in this issue.

EARI. F. LOVELL, EXECUTIVE DIRECTOR
THE AGE OF RECOVERY

Good afternoon, Madam Chairlady and distinguished members of the panel. I have been the Executive Director of the Age of Recovery and before that, the Fendall House, for over seven years. The facility itself has been in service for over twelve years. During this time, we have been engaged in the daily care and supervision of St. Elizabeths Hospital outpatients, patients on convalescent leave, and patients who have been discharged. During these years, District of

Columbia community-based mental health has undergone a number of changes - some were for the better, some were not. What we have before us now with respect to OMB's proposal is really nothing more than still another thrust toward the Federal Government's ultimate goal of divesting itself of SEH and its attendant responsibilities. These efforts have been ongoing for at least the last five years. We should not be surprised or shocked at this, the latest effort. Our real problem is that we have not - at least until now - considered these efforts to close SEH and/or transfer it intact to the D.C. Government as real, serious enough possibilities to warrant our attention. The present administration's demonstrated actions thus far now, I believe, should give us more than adequate cause to believe that this time the threat is genuine and significant. It may be of interest to those here today to know that over two years ago I suggested a plan of action to various officials of the city (those in position to act) regarding positive steps to take in order to prepare for "the day." As we know, SEH is located in the heart of Anacostia, S.E. Washington. This is generally acknowledged to be the poorest section of the city by just about any standards anyone would care to use. Because of this deprived and disadvantaged area of the city, it would behoove any right minded politician or civic leader, in my view, to concentrate maximum efforts toward the economic development of this area. Here, then, are the essential ingredients of a plan of action which will eventually solve the Federal dilemma of what to do about ridding itself of SEH and the District's even more perturbing problem of ways and means to bolster the economic base of Anacostia.

First: Transfer all grounds and buildings except for, say, 100 acres to the District of Columbia. This transfer should be by quitclaim accompanied by sufficient Federal financial assistance to insure an orderly transfer and preparation for subsequent development. This action should net the District over 200 some odd acres of choice ground for further community development, i.e., housing, shopping center(s), apartment buildings, etc. Sales of parcels to developers itself should create a very substantial income. Long term and more meaningful advantages would be the sizeable increase in the city's tax base and the addition of jobs, jobs, jobs!

Second: Again with initial, one-time Federal financial assistance, build an all new 2500 bed acute care mental hospital. Perhaps using the fairly new area D Dix Building as a starting point. In my opinion, 2500 beds should be adequate to address the city's acute care requirements. Especially since we have other acute care facilities in the city which can and do treat mental cases. Once the new hospital is established, retain it under D.C. ownership and cognizance but not D.C. management. In my opinion it would be far better to lease the facility to a private, non-profit, professional hospital management organization.

Third: The District of Columbia must come to grips and meet head on the ongoing problem of providing adequate financial and service support for community based health care facilities. There will still remain some 10,000 or so mental health patients who will continue to need full time care in a community setting. A large part, if not all, of the monies required to support an effective community based program can be derived from the income generated through the first and second steps preceding.

In closing, I believe that President Reagan will not see fit to summarily close SEH in the near future if for no other reason than both the D.C. Government and the Federal Government are woefully illprepared to accept the consequences. What possible alternative(s) exist today which could adequately assume the role and responsibility of SEH? There is none. However, we can no longer afford to keep our heads in the sand! We need to act now because I firmly believe that ultimate closure and/or transfer of this Federal facility is just a matter of time. And not much time. We have had more than ample warnings in the past - this latest one must be taken with all seriousness.

Thank you for this opportunity to voice my beliefs.

GERALDINE P. BOYKIN, EXECUTIVE DIRECTOR
D.C. COUNCIL 20

AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO

Fellow D.C. citizens, I am Geraldine Boykin, Director of D.C. Council 20 of AFSCME, The American Federation of State, County, and Municipal Employees, AFL-CIO. AFSCME Council 20 represents most employees at St. Elizabeths Hospital, as well as workers at local community mental health centers.

D.C. citizens are faced with a crisis in mental health care. David Stockman's office has proposed cutting the budget of St. Elizabeths in half. Health and Human Services Secretary Schweiker has appealed this to the President, but his alternative plan calls for cutting the Federal appropriation by twelve million dollars and one hundred thirty-eight jobs, and calls for additional cuts in the future.

Secretary Schweiker proposes to make his cuts by dumping the hospital onto a so-called "Public Corporation." Under this proposal, neither the District nor the Federal Government would control the hospital. As a result, neither level of government could be held politically accountable for funding and running St. Elizabeths, and it would be easy for Reagan's Congress to make deeper cuts each year.

It would be virtually impossible for the financially-pressed District Government to offset these cuts. As a result, even more patients would be dumped into boarding homes like the one on Lamont Street where ten former patients died in a fire, or dumped onto the streets. Unfortunately, Mayor Barry has agreed in principle to this proposal, thereby giving Reagan a blank check to make cuts.

Reagan says cut back, but we say fight back! We want to help build a citizens' coalition against the Reagan cuts. We must convince Mayor Barry and Congress to reject these cuts. The nation's Capitol must not become a psychiatric ghetto. We stand ready to work with you in this effort.

Thank you.

JOYCE R. FORREST, PRESIDENT-ELECT
ANCHOR MENTAL HEALTH ASSOCIATION

In the 24 year history of the Anchor Mental Health Association, we have seen St. Elizabeths Hospital go from an institution with approximately 8,000 inpatients, most of whom were hospitalized for long periods of time, to an institution with approximately 1,900 inpatients. AMHA notes that those who were the easiest to deinstitutionalize, have been. We are now seeing a more severely disabled population, which is in need of more frequent and easy access to St. Elizabeths because of the cyclical nature of their illness which involves repeated regressions or relapses.

Anchor Mental Health Association applauds the work done by St. Elizabeths Hospital, the local government, and private aftercare providers to deinstitutionalize mentally disabled persons so that those who are able, can live in the community in the least restrictive way and to their maximum potential.

AMHA recognizes the following:

first -- that many mentally disabled people, after a brief hospitalization during which their condition can be stabilized with medication, are able to live in the community and hopefully are able to enjoy happier, more productive lives.

second -- that many who return to the community may, for a variety of reasons, need to return periodically to the hospital.

third -- that some may never be able to return to the community.

fourth -- that those who have been in the hospital for a long time view the hospital as home and the staff as family. The hospital is their greatest support and security.

AMHA further wishes to point out:

first -- that the efforts to reorganize and improve services at Community Mental Health Centers is a recent, uncompleted task.

second -- that there are relatively few private providers compared to the numbers who need their services and that the quality of services rendered varies greatly.

third -- that the beds available for Medicaid-eligible patients at local hospitals are not able to provide services for the more chronic patient or for the criminally mentally disabled as at St. Elizabeths John Howard Pavillion.

AMHA believes that the proposed closing of St. Elizabeths Hospital is an effort by the Federal Government to cut the budget and its financial investment in this hospital without regard for the well-being of the mentally disabled. The District of Columbia Government could not support St. Elizabeths Hospital without the federal budget allocation, and the formation of a corporation to operate St. Elizabeths is a decision not likely to be implemented to the agreement of concerned parties in the foreseeable future.

Finally, AMHA points out that while a significant number of patients served at St. Elizabeths are technically residents of the District of Columbia, their place of origin is national in scope.

Thus, the Anchor Mental Health Association of the Roman Catholic Archdiocese of Washington is unequivocally opposed to the closing of St. Elizabeths Hospital and to the reduction of the Federal Government's financial commitment to St. Elizabeths.

RICARDO GALBIS, M.D., EXECUTIVE DIRECTOR
ANDROMEDA HISPANO MENTAL HEALTH CENTER

We feel that we have contributed to the public hearings on Mental Health in the District of Columbia by stressing the role of community based service organizations such as Andromeda. At Andromeda we have provided outpatient mental health services for the past eleven years concentrating primarily on the Spanish community. We feel that with the increasing cuts in the Federal programs the grass root community agencies are placed under more pressure to provide services to an ever increasing population. One of the real problems that we face is the influx of the Cuban and Salvadorian refugees, with their attending social and mental health problems. The organization of the city's mental health services, and their integration with the services provided by St. Elizabeths Hospital should take into account the special needs of minority groups such as Hispanics and Blacks. The integration of services with the individual agencies such as ours and the Institute of Mental Hygiene should be accompanied by financial support either by the city or by the semi-private corporation that will head up St. Elizabeths. We should also be able to better serve the community through high quality care which can only be obtained at a price for the hiring of adequate professional staff. As a closing remark, we should say that the deinstitutionalization brings hundreds of new clients to our community services.

PHYLLIS MARTIN, PROGRAM CHAIRMAN
VELVIN DABNEY, CHAIRMAN OF BOARD
AREA C POLICY BOARD

We of the Area C Policy Board have been involved since 1968 in the process of trying to improve mental health services and to educate D.C. residents on prevention and problems of mental health. We have been also involved both personally and professionally with St. Elizabeths, including testimony on numerous occasions before Congressional Committees (including Rep. Diggs) and local committees on the future of St. Elizabeths.

We have never supported the "closing of St. E's," since we feel that it is a necessary resource to continue delivery of services to D.C. residents. We support the concept and structure of St. Elizabeths, but have problems with the level of services as currently and actually delivered. Though accredited by JCAH, we see no improvement in treatment and follow-up services (overall). In reality we see top heavy administration and many staff meetings. We have also visited numerous times and seen patients left to themselves, arguing, etc. while staff look at TV. Are evening and weekend activities offered? How many patients elope? We are also informed that more staff time is spent in meetings, leaving little time for patient treatment services.

We originally supported the Corporation concept so long as it provided for a majority membership of local residents. If this is not provided there will be

the same pattern of ignoring local complaints of lack of adequate treatment, follow-up etc. We in the front lines of the community (not living in ivory towers) see patients discharged too soon or without adequate placement and follow-up and observe the heartrending living, financial and emotional problems of patients who soon return to the institution.

Again, we support St. E's as a resource, but one in need of much improvement in patient care considering the annual budget and in spite of JCAH accreditation.

We have a suggestion which is that the various mental health groups form committees to visit unannounced at different times (all hours) to evaluate patient care and activities and follow-up. Also tour with ex-patients and families who attempt to use resources in D.C. (private and public). Come out of the ivory tower.

Again we thank you for this opportunity to present our views, experiences and suggestions.

BARBARA MOORE, MENTAL HEALTH COUNSELOR
AREA D ALCOHOL & DRUG ABUSE PROGRAM

The closing of or curtailing services at St. Elizabeths Hospital is preposterous. I question whether Mr. Stockman and OMB are looking at St. Elizabeths Hospital as a financial statistic or for what it really is, a hospital treating and servicing people. If it is viewed as a financial statistic then it appears that according to Reaganomics it could be obliterated, but if it is viewed totally, the concept proposed is ridiculous. What does Mr. Stockman and OMB propose for the people who find themselves in need of the treatment and services provided by St. Elizabeths Hospital? Where will they go? As so many of the social services available to those who may be listed as the "have nots" are already cut or in the process of being cut, what are their alternatives?

As an employee of St. Elizabeths Hospital, I have very strong feelings about the treatment and services we provide. I become annoyed when only the negative view is adversely publicized. There are so many positive things about the hospital which are not commonly known. With so much emphasis being placed on the number of inpatients serviced/treated at the hospital, the number of patients who are returned to the community as productive, useful, tax-paying citizens is somehow seldom addressed publicly.

True, it takes a lot of money to operate a facility such as St. Elizabeths Hospital but how can you put a dollar sign on human lives? And we must say human lives for without the treatment and services offered at St. Elizabeths how would these people survive?

Due to the purpose of St. Elizabeths, I ask that Mr. Stockman and OMB reconsider their proposal and let us continue providing the services and treatment necessary for mental health.

RUTH E. G. KING, ED.D, CHAIR-ELECT
D. C. CHAPTER OF THE ASSOCIATION OF BLACK PSYCHOLOGISTS

INTRODUCTION

History indicates that St. Elizabeths Hospital was originally a military hospital used for veterans and military personnel who suffered from "shell-shock" and other psychological disorders resulting from war. Over the years, St. Elizabeths has become a public mental health facility serving the D. C. metropolitan area. For the past several years, the federal government has been trying to "dump" St. Elizabeths on the District of Columbia. Under the present administration, Stockman and OMB have proposed to cut the budget or close the hospital entirely. The first question we, the D. C. Chapter of the Association of Black Psychologists pose is: "What has happened to the plans to set up a quasi-governmental/public corporation to fund and manage St. Elizabeths Hospital? It is our understanding that a great deal of work went into developing plans that have been left hanging in limbo. Is the corporation idea a feasible alternative to drastic cuts or a shut-down? We oppose the complete closing of St. Elizabeths at this time!

ISSUES

Let's look at the reality of the situation. St. Elizabeths has two systems of patient care; one superior, one inferior. Patients are housed according to where they live in the District; hence the units which house patients living outside the Rock Creek Park area have better care and "top-notch" out-patient facilities and care. Those units which house patients from downtown Northwest, the Southeast, the Southwest, and Northeast who are mainly Black, receive the "other" care. So in essence, we are looking today at the impact of releasing mentally ill patients back into the predominantly Black neighborhoods of Washington, D. C. What are some of the impacts of closing or curtailing service at St. Elizabeths Hospital?

1. A drain on existing D. C. mental health and social service facilities.

- o The D. C. Government cannot possibly absorb the patient care of those presently hospitalized at St. Elizabeths, due to lack of staff and resources.
- o Attempts to adequately implement mandates from the deinstitutionalization law suit are currently failing due to:
 - lack of housing
 - lack of staff and resources
 - lack of adequate social service supports
 - lack of transportation for patients, etc.
- o Presently Area B Community Mental Health Center cannot adequately absorb the clinical care of the patients from only one unit of St. Elizabeths, due to staff shortages and lack of resources.
- o The other medical hospital have time limits on psychiatric patient stay and do not provide unlimited custodial care that many patients need.
- o Other social services offered by agencies such as the Salvation Army, city shelters, etc. are not equipped or staffed to handle mentally ill patients.

2. Displacement of people

- o Many families have deserted these patients and the hospital has no knowledge of the location of any living relatives; patients have NO WHERE TO GO!
- o While "Halfway Houses and community residential settings may be adequate for some patients who do not have severe disorders; many patients cannot feed, clothe or manage themselves in such a facility. These chronic patients need total hospital care.
- o Most Black patients cannot afford private care; for others, the family has exhausted insurances that would support the care provided by private therapists or private institutions.
- o Other patients need constant care rather than extensive therapeutic services: for them, the hospital support system is essential.

3. Devastation of family systems

- o Some patients who are chronically mentally ill need one or two of the hospital staff to watch them to prevent them from harming self or others.
- o Many patients cannot dress or feed themselves.
- o Some patients engage in violent behavior and need to be restrained.
- o Most families have working adults and no one with the time to provide constant 24-hour type care in the home. The social and psychological impacts on the family would be awesome and over-burdensome.

4. Death and increased crime

- o Statistics indicate that schizophrenics have a shorter life expectancy than the average person.
- o Most schizophrenic patients at St. Elizabeths are sicker than average and do

not respond well to medication; hence without the hospital support system, they are expected to die sooner.

- o Suicide and homicide are likely to increase; case in point, the recent killing of a D. C. teenager by a mental patient.
- o Statistics indicate that paranoid schizophrenics commit more crimes than others. We have the case in which a patient who was discharged came back into St. Elizabeths and raped and robbed three nurses.
- o Most patients are not skilled or stable enough to work. They are more apt to take what they want from stores, neighbors and/or family. Jails are already over-crowded and are not equipped to deal with large numbers of mental patients.

5. Devastation of communities

- o There is evidence that when patients are released from St. Elizabeths and have NO PLACE TO GO, they tend to stay in the immediate hospital area.
- o There are current complaints from the neighborhoods surrounding the hospital of former patients who:
 - indecently expose themselves publically
 - lay in the street in front of cars
 - take food and other goods from local stores, etc.
- o The present deinstitutionalization efforts are often unsatisfactory for patient and community.
 - people are placed in "houses" with minimal follow-up care
 - there is seldom adequate professional staff to provide the type of group interaction or therapy which helps patients separate reality from their pathology
 - social workers or psychiatric nurses who may assist with care in such facilities have tremendous case-loads and cannot provide the kind of care required
- o Fear, resentment, and hostility by the community residents don't help the patients with "adjustment" to a new living environment and may enhance the existing disorder.

CONCLUSIONS

The D. C. Chapter of the Association of Black Psychologists opposes the closing of St. Elizabeths Hospital or the curtailing of service at this time. The District Government is NOT geared up to absorb the patient support or care needed for those patients. As indicated before, many patients would end up in the penal system. Estimated patient care costs at St. Elizabeths is \$200 - \$350 per day while it costs the District \$500 - \$600 per day to house someone in jail. The CMHCs and other social agencies would be over-loaded and they are ill-equipped with staff and resources to provide adequate care. Most of these patients cannot work and would need a variety of social services which have already been limited due to the budget cuts. Where will patients go? Where will patients receive needed services? Is Ronald Reagan going to take them in at the White House? Is Stockman or OMB going to allow use of their office building for housing?

We recommend that the Federal and D. C. Governments re-examine and re-explore the corporation management idea of sustaining St. Elizabeths Hospital as well as exploring other alternative approaches. We also advocate proportional distribution of staff and resources to provide for the community care of those patients who have been moved as mandated by the deinstitutionalization suit. The re-assignment of fifty (50) staff to the District to help provide administration and services for approximately 2,000 patients is hardly proportional when almost 2,000 staff remain at the hospital facility to care for the remaining 2500 patients. Focus on the chronically mentally ill has had the result to cutting off services for mildly ill patients and virtually eliminates preventive efforts. DCABPsi favors a thorough examination of the present inadequacies of the present deinstitutionalization efforts and the provision of support staff and resources for that effort before laying the burden of St. Elizabeths on Washington, D. C. Surely the "swift" minds of this administration can meet the challenge of providing an equitable plan of care for patients of St. Elizabeths Hospital.

BARBARA BASKERVILLE, IMMEDIATE PAST PRESIDENT
BLACK NURSES ASSOCIATION OF THE GREATER WASHINGTON AREA

As an advocacy group for both citizens and nurses, The Black Nurses Association of the Greater Washington Area, Inc. strongly opposes the OMB's proposal to close or curtail services at St. Elizabeth Hospital. Among our membership are administrators, clinical specialists, educators and staff nurses with expertise in the area of psychiatric-mental health nursing. Therefore, we feel that we can address the mental health needs of this community from several perspectives.

First, the need for the hospital. St. Elizabeth Hospital is the only public mental health facility which provides both short and long term care to the citizens of the District of Columbia. The focus of the private hospital continues to be short term treatment. Given the economic situation and other life stresses, there will continue to be a significant segment of our citizenry which will require mental health care.

Second, can the average citizen afford to pay for care in a private hospital? Consider the fact that one of the major health insurance carriers has just decreased the amount of coverage specially for mental health services.

Third, what are the community resources available to absorb the large number of patients at St. Elizabeth. Currently, there are an inadequate number of mental health centers, group homes, etc. How will the patients released sustain themselves and meet their basic needs? What will be the response of the community?

Lastly, what about the health care workers? What will happen to the more than 2,000 employees at St. Elizabeth? Currently the unemployment rate hovers around 9%. Will another large group further lengthen the long lines for unemployment compensation and public assistance?

There are many complex and unanswered questions. There are no easy answers. These questions warrant thoughtful, scientific and deliberate responses.

Please consider the aforementioned factors and allow this community and its citizens to retain a place to nurture its mentally ill.

MARY F. SCOTT, PRESIDENT
CAPITOL ASSOCIATION OF COMMUNITY RESIDENCE FACILITIES, INC.

I would like to thank the Mental Health Association for allowing me the opportunity to testify at this hearing.

As an operator of a Community Residential Facility for the Mentally Ill and the Handicapped I am very concerned about the rumor of the closing of St. Elizabeth Hospital and we sincerely hope that it is a rumor.

Our clients are so confused about this rumor. Many have just been approached by their social worker and their doctor about being discharged from St. Elizabeth Hospital and if things did not work out with the discharge, St. Elizabeth Hospital and staff would be there for their support. If St. Elizabeth Hospital is closed it will be disastrous for most.

It presents great problems for us as operators. The clients are upset most the time, we are constantly counseling them on a one to one bases, trying to reassure them that we will support them in anyway we can and that all services needed will continue no matter how small or great.

My clients reply is that the President does not like old people and that he gets his way about everything he has asked for and we are afraid that he will get his way about closing St. Elizabeth Hospital. If you are old and mentally ill no one really cares about you, not even your family. With St. Elizabeth Hospital being closed we have nothing to even look forward to. This is a time we should be enjoying the fruits of life and all we have to look forward to is problems and more problems.

We as operators of the Community Residential Facilities pray that St. Elizabeth Hospital is not closed for most of our clients who have spent twenty or thirty years there. If their living in the Community did not work out they at least had the support of St. Elizabeth Hospital and staff who have been their support in the past.

MITCH SNYDER
COMMUNITY FOR CREATIVE NON-VIOLENCE

The proposed closing of St. Elizabeths Hospital is tantamount to signing a death warrant for hundreds of homeless people now on the streets of this city and for untold numbers of the patients now hospitalized. Any significant budget cuts at the hospital - resulting in more stringent admission or readmission criteria, shorter stays, or even fewer support services - will have the same result.

We should have learned our lesson from the nightmare of deinstitutionalization to this point. After-care and rehabilitation are virtually non-existent for the overwhelming majority of mentally handicapped persons. The truth is that the mentally disabled require not more services but a more decent life. Central to that is the need for safe and humane shelter.

Already the waiting rooms of our city - hospitals, courts, welfare offices, soup kitchens - are daily filled with an ever-circulating segment of the poor and homeless. Among these people are many deinstitutionalized patients. To say that their homelessness does not help their condition is a cruel understatement. Yet equally dangerous is the reality that the barbarity, risk and pain of street life do nothing but encourage mental and emotional trauma.

There is an acknowledgement, by virtually everyone short of the Mayor's office, that existing shelter space in this city is far from adequate. A few hundred beds - intended as emergency provisions - have de facto become long-term refuges for people who are devoid of resources or relationships that could offer them anything else. Existing shelters are consistently filled, and homeless people must instead turn to heat grates, alleys, and abandoned cars and buildings as places to stay. A large portion of those who already suffer this way are hidden from view. We have no way of gauging, for example, how many homeless deinstitutionalized people die each winter from cardiac arrest or pneumonia, so those in daily contact with the homeless must make judgments based on the already monumental pain we witness constantly.

With new beds coming into existence with reluctance and by the handful, any new strain on existing space - whether from socially aneurysmal factors such as increasing unemployment, spiralling housing costs, or slashes in social spending - causes the burden and the competition to fall on those in need. The competition is real and fatal. Even the most ambient shelter - literally available to those with fewest "problems" - drives away those in need when it is overcrowded, alien, or not perceived as different from other alternatives. The price of no shelter is, at worst, death.

The situation is already critical for those who are on the streets. Their numbers cannot be increased - as they inevitably would be - by cutbacks or closing at St. Elizabeths. To do so would only increase the rolls of casualties.

For the mentally disabled on the streets, therapeutic and survival imperatives are intimately linked... Advocacy on behalf of the homeless must be double-edged and consciously so. It cannot fail to demand the improvement and expansion of present mental health and social services at the same time as it must insist upon a reconceptualization both of the problems of disability and dependency and, in turn, of the appropriate public response to them. Specifically, shelter should be recognized as a basic human right; its denial, therefore, should be seen as an affront to justice and decency.

from Private Lives, Public Spaces

To release a single patient from St. Elizabeths under other than these conditions would be nothing short of criminal.

Rather than make this statement a heavily academic one with footnotes and the like, we would like to append a few suggestions that encompass vital reading on the problem described above:

1. "Deinstitutionalization; A Critical Analysis" by Ellen Baxter, written for the School of Public Health, Columbia University, October 1977.
2. Private Lives, Public Spaces: Homeless Adults on the Streets of New York City by Ellen Baxter and Kim Hopper for the Community Service Society of New York, February 1981.
3. A Forced March to Nowhere/Homelessness: A National Priority, Report of the Community for Creative Non-Violence prepared for the House District Committee, September 1, 1980.

HAROLD I. EIST, M.D., MEDICAL DIRECTOR
THE D. C. INSTITUTE OF MENTAL HYGIENE

A decision to close or severely cut back the programs at St. Elizabeths Hospital at this time could have a disastrous effect on the Washington community. The desire to release mentally ill patients into the community before appropriate programs have been set up to receive them has been proven enormously costly in terms of human suffering, increased crime rates, overburdened out-patient facilities and tax waste. We are all too familiar with the scenes in New York, Boston, and other major cities where discharged patients wait out their lives in submarginal housing, with poor nutrition and little or no medical or mental health treatment available.

Washington, D. C. has been struggling for years to resolve the problem of institutionalized patients and is presently under court order to do so in a reasonable, timely fashion. Closing St. Elizabeths Hospital precipitously will assure that the present plans, which are still in the state of development, and some distance from actual utilization, will be sure to fail.

At this very moment, Medicaid funds, on which many of these patients are dependent, are being cut back, and low income mental health patients in the community are being removed from the Medicaid rolls. At the same time the local out-patient public mental health system is being reduced dramatically, and its ability to provide appropriate out-patient treatment and medical service to thousands of discharged patients has been severely compromised.

The D. C. Institute of Mental Hygiene now provides over 60% of the out-patient treatment available to the poor and near poor in Washington, D. C., but it has been unable to arrange appropriate contracts with the government to provide service to the many patients who are not ineligible for Medicaid, have no or little insurance coverage, and are unable to afford private care, even though the court mandates that such care be provided.

The only logical solution to the pressing problem of de-institutionalization is to focus attention and funds on the community network that provides the continuity of service necessary for successful placement of mentally ill persons into the community. Until this network is in place and working effectively, closing St. Elizabeths would be reprehensible. The OMB must also face the reality that some form of institutional care will always be necessary for those patients who cannot be treated on an out-patient basis.

M. KATHLEEN MCINTYRE, LEGISLATIVE COORDINATOR
D.C. NURSES ASSOCIATION

On behalf of the D.C. Nurses Association, I would like to express our concern over the proposed cuts in services, if not actual closure, of St. Elizabeths Hospital.

While nurses have consistently supported streamlining health care costs and shifting some resources from acute care to health promotion/disease prevention; we do wonder about the wisdom of a decision that would limit, if not remove, inpatient care for the emotionally disturbed indigent of the District of Columbia.

We applaud your attempts to learn through the community hearing of the impact of such cuts on those involved and we offer whatever assistance we can to your plans for resolving the situation.

MARGARET IVES
D. C. PSYCHOLOGICAL ASSOCIATION

Perhaps because I was a member of the Saint Elizabeths Hospital staff for thirty years, I am particularly interested in the history of a hospital which has given 120 years of excellent service to the cause of alleviating mental illness, locally, nationally, and around the world.

In 1968 I was privileged to attend in London the twentieth anniversary of the World Federation for Mental Health, of which our former Superintendent, Dr. Winfred Overholser, had been one of the founders. The opening ceremonies were held in Westminster Abbey. There, in brief comments on the history of the mental health movement, the Dean of the Cathedral told of the removal of chains from mental patients by Pinel in France in the late 18th century, followed by similar advances in England under R. Tuke. For the United States he considered our outstanding contribution to be the founding of Saint Elizabeths Hospital through the efforts of Dorothea Dix.

This acclamation, of course, delighted me. I remembered the welcome I had received a few years before in both Japan and Thailand, when I had told my hosts that I was on the staff of Saint Elizabeths Hospital.

Outstanding physicians have always headed Saint Elizabeths, but it was William Alanson White, (Superintendent 1903-1937) who first made the hospital internationally known. His prolific writing and fluent speaking initially brought this about, but equally, if not more important, was the development of the Hospital as a training and research center with students from around the nation and around the world. During World War II, hardly a theatre of war was without its contingent of psychiatrists and others who had been trained at Saint Elizabeths. When I first came to Saint Elizabeths in 1943, hardly a week went by without distinguished visitors from all over the United States, the Western Hemisphere, and the world. They came to find out about our methods and incidentally increased our understanding of how patients were treated elsewhere. Dr. Winfred Overholser, who succeeded Dr. White, was superintendent then, (1938-1963) and under his administration, the national and international reputation of the Hospital continued to flourish.

Saint Elizabeths was well known for its initiation of new methods of treatment which were later to be widely adopted. Dr. White established a Department of Internal Medicine in 1920 and as a result, Saint Elizabeths became the only public mental hospital in the United States approved for rotating medical internship. Shortly thereafter, malarial therapy for general paresis was introduced and used for the first time in the western hemisphere. Later, in 1939, the hospital had the first electroencephalography in the District of Columbia.

From a more strictly psychiatric viewpoint, Freudian psychoanalytic concepts were first introduced into the United States by Dr. White and were utilized widely at the Hospital. Also both Dr. White and Dr. Overholser were pioneering experts in the field of forensic psychiatry, wrote and lectured widely on the subject, and made of our forensic division a nationally known center where many professionals came for instruction.

From a psychologist's viewpoint, very important is the establishment in 1907 of the first psychological laboratory in a mental hospital to have an unbroken history until the present day. Research and training flourished under the first psychologist, Dr. S.I. Franz, who was a nationally known figure and who pioneered while at the Hospital in the rehabilitation of brain-injured World War I veterans. He was director of the pathological laboratory, another innovation of Dr. White's for a mental hospital.

History, while fascinating is not enough. Times are changing and now it is important that Saint Elizabeths, situated in a metropolitan area, provide mental health services to the community and be a part of that community. To do this effectively it must continue to be a leader in training professionals and other mental health workers and must pioneer in discovering new and better methods of treatment through research. As a federal hospital it can emphasize national

goals in the mental health area and can exert leadership which state and local institutions may follow without needing to be competitive. It can recruit outstanding staff and leaders nationwide and can attract professionals who would not be interested in applying to a local institution.

Also it can continue with innovations. Comparatively recently a center for training deaf psychotics, a speech and hearing branch, and a rehabilitation center with mobility training for the blind have been established. These are certainly not common in mental hospitals and are doing an excellent job, not widely publicized.

In 1967 Saint Elizabeths was removed from its independent status under H.E.W. (now H.H.S.) and placed under N.I.M.H. A year later plans were announced to make Saint Elizabeths a national center for services to patients, training of mental health professionals and other workers, and research which would improve methods of treating the mentally ill. It was to be a model for the nation. It sounded very good.

But all did not go well. Only one more year had passed when in 1969 it was proposed that Saint Elizabeths Hospital be transferred from the jurisdiction of the United States Government to that of the District of Columbia. Why? Had one year already demonstrated that the Hospital was incapable of becoming a national model? Had it been established or was it believed that the District of Columbia was equipped to make of the Hospital a more outstanding center than it had demonstrated itself to be during its more than a century of existence? Were there indications that excellent staff could be more easily recruited by local authorities? Did the proposers of the transfer believe that the patients would receive better care?

No, none of these justifications was given as the reason for the transfer. It was budgetary, to save money for the federal government and to reduce the funds and personnel needed for H.E.W. To be sure, most of the patients were and are residents of D. C., but is any state or local hospital better equipped to support an outstanding national mental health center than is the Federal Government? Can a local government more easily recruit excellent staff or give the patients better care? Can it more adequately support research? These are the outstanding issues.

Perhaps the proposal of a Corporation to be in charge of the Hospital is the best solution. If the members of such a corporation, representing both the Federal Government and the District of Columbia, could enter into a co-operative relationship in which the best mental health care for patients was the predominant concern, the Hospital could again become outstanding. Inpatient and outpatient care could be co-ordinated and excellent staff could be recruited. Whatever the solution, we cannot turn 2,000 very sick or disturbed patients onto the street with no hospital at all. That is unthinkable.

It seems to this witness that, in these uncertain times, the Federal Government would wish to maintain and improve any of its institutions or activities which enhance the international reputation of the United States. As was pointed out at the beginning of this paper, Saint Elizabeths Hospital has been held in high regard in Europe, Asia, and the United States for over half a century. Only recently does it seem to be losing its reputation. But without the funds to run it properly, without the resources to recruit outstanding staff, without its research and training excellence, its reputation cannot long remain high. Nor should it.

Let us cherish, support, and maintain, wherever we have them in the United States and in its government, those institutions and activities which are excellent.

MARILYN KRESKY-WOLFF, MEMBER
D. C. STATE MENTAL HEALTH ADVISORY COMMITTEE

I am here today as a representative of the State Mental Health Advisory Committee (SMAC). I chaired its Deinstitutionalization Work Group last year, which helped in the preparation of the State Mental Health Plan for 1982-86. I have also directed two of Woodley House's programs over the past several years, the Apartment Program, and Crossing Place, the alternative to hospitalization for people in severe psychiatric crisis. I have served on needs assessment panels for the Dixon Plan and will be serving on some of the contract monitoring teams.

The primary point I would like to get across today is: State Health and Mental

Health planning and the accompanying advisory groups are no longer federally-mandated services, but local jurisdictions can retain them and allocate resources to see that planning continues. This is vitally important in the District. The example of OMB's proposal vis a vis St. Elizabeths, shows that Congressional or federal executive branch action can slash budgets for St. Elizabeths, the major in-patient facility for the indigent mentally ill in the District. Planning is crucial to anticipate such actions and suddenly reduced resources since the planning process identifies priorities and the most pressing needs along the way, making allocation decisions easier when there are fewer resources than anticipated.

During the past year, the mental health system in the District of Columbia has experienced the negotiation of the Dixon plan, the reorganization and shrinking of the community mental health centers, the proposed federal corporation to unify St. Elizabeths and the D. C. Mental Health Services Administration into a single system, the reduced mental health funds for D. C. in the federal block grant, the cut-backs in mental health coverage by the major insurers for federally-employed District residents and dependents - and now the threatened cuts at St. Elizabeths.

We know this dizzying array of events takes a toll on staff trying to preserve their jobs, administrators trying to piece funds together. I doubt, however, we can even begin to measure the extent of panic, uncertainty, and abandonment that must exist among in-patients, out-patients, and their families who wonder where or if treatment will be available, and how or if it can be paid for. An advisory group such as SMHAC which is composed of citizens, providers, and consumers, projects the needs of our mentally ill citizens over a five-year period and reviews short-term effects of changes in the mental health delivery system.

One of the results of the twists and turns in events regarding St. Elizabeths is that many of us testifying today will take a basic position against abrupt phasing-out of St. Elizabeths. On the other hand, a number of us recently appeared to be on the other side of the fence when we learned of a possible Congressional effort which would water-down the concept of "least restrictive alternative living arrangement" and substitute language which would essentially sanction a return to prolonged stays in institutions. Had District providers and advocates been asked to testify in the November hearings of the House District Committee, many of us would have argued against increased use of St. Elizabeths.

The point is not that we are two-faced - it's that the long-range solution for successful deinstitutionalization doesn't call for either increased utilization of institutions as some in the Congress appear to be contemplating, or abrupt shut-downs of institutions, as OMB appears to be recommending. Rather it calls for planned, gradual curtailing of hospital-based services, and planned gradual replacement of those services with community-based services, with an attending transfer of funds and staff.

The Dixon Plan implementation has recently begun. The Plan was negotiated by the Mental Health Law Project representing the plaintiffs, the District government, and St. Elizabeths. The private sector is participating by providing eighteen services under contract with Mental Health Services Administration, and continues to provide transitional services under contract with St. Elizabeths. The Deinstitutionalization Work Group which included a wide range of providers, public officials, advocates, and consumers, identified the continuum of services needed by veterans of psychiatric hospitals. These services corresponded with the services mandated by Dixon. Thus, we have a rare occasion in a community in which public and private providers and consumers have met to negotiate a sane plan for deinstitutionalization, and agreed to the components and the timing. The process of transferring patients from St. Elizabeths rolls to mental health center rolls, and the utilization of community-based services, though a slow process, already has begun to show great promise. In this light, one wonders if OMB actions imply a financial decision which will be made whether or not the decision-makers are cognizant of previous deinstitutionalization disasters, such as occurred in New York City, where there was inadequate planning in communities to receive people who were discharged from hospitals.

It is abundantly clear from my vantage point that the private sector - both for profit and not-for-profit is not geared up at the present time to serve the numbers of people who would be without treatment, shelter, and basic necessities if St. Elizabeths services were phased-down in advanced of what the Dixon Plan has already addressed. Contracts would have to be expanded, new contractors found, and in-patient service contracts would have to be developed with area general hospitals for those persons in need of acute psychiatric care. Living arrangements would

have to be found for the long-term stayers at St. Elizabeths who, because of disability and chronicity, cannot be served in existing community residence facilities.

The District of Columbia is one of a few select communities in the United States where the stage is set for testing the success of deinstitutionalization through the development of an adequately coordinated and funded community-based system. This process should not be disrupted. We must fight hard against efforts to reverse years of sensitive planning for persons with chronic emotional difficulties in our community.

LINDA A. MOODY, CHAIRMAN
D.C. STATEWIDE HEALTH COORDINATING COUNCIL

The D.C. Statewide Health Coordinating Council is concerned about the Office of Management and Budget's proposal to close St. Elizabeths Hospital.

The letter which follows was sent to David Stockman, Director of the OMB, to convey the SHCC's concern about the serious impact which closing St. Elizabeths Hospital would have on the mental health system in the District of Columbia.

Honorable David A. Stockman
Room 252
Old Executive Office Building
Washington, D.C. 20503

January 4, 1982

Dear Mr. Stockman:

At its December 3, 1981 meeting, the D.C. Statewide Health Coordinating Council (SHCC) passed a resolution requesting that a letter be sent to you expressing their concern about the Office of Management and Budget's proposal to close St. Elizabeths Hospital.

St. Elizabeths Hospital represents a major part of the mental health care system in the District of Columbia, providing services for approximately 2,000 inpatients, and more than 3,000 outpatients. Most of these patients are District residents.

Although St. Elizabeths is a Federal facility, the SHCC is concerned about the significance of the Office of Management and Budget making such an important decision without consulting the SHCC, which has the responsibility for developing the comprehensive health plan for the health system in the District of Columbia.

The proposed closure of St. Elizabeths Hospital will have a significant impact on the District's mental health system. Because of this impact, the SHCC should be involved in any deliberations concerning this major issue.

I would appreciate receiving a copy of the proposal for closing St. Elizabeths Hospital and I would like to request that you or a representative from your office attend a future SHCC Executive Committee meeting to discuss this issue in more detail. You may contact Ms. Claudia Richards, SHCC Coordinator, at 727-0744 to arrange a meeting date and time.

Thank you for your assistance regarding this matter.

Sincerely,

Linda H. Moody

Linda H. Moody, Chairperson
Statewide Health Coordinating
Council

JAMES A. BUFORD, DIRECTOR
DISTRICT OF COLUMBIA DEPARTMENT OF HUMAN SERVICES

Good afternoon, members of the Mental Health Association of the District of Columbia, Ladies and Gentlemen. Thank you for the the invitation to appear before you and to comment on the Saint Elizabeths' budget. Because the President has not submitted his 1983 budget to the Congress, I cannot speculate on the hospital's future financial status. Instead I will focus my remarks today on the role of Saint Elizabeths Hospital in the public mental health delivery system of the District of Columbia.

As you are all aware, Saint Elizabeths Hospital was created by the U. S. Congress in 1855 by Federal statute. Known as the Organic Act, the law creates a federal institution for the care and humane treatment of the mentally ill on 336 acres in Southeast Washington. While this facility serves a number of special populations, such as veterans and foreign nationals from abroad, Saint Elizabeths Hospital has the authority and responsibility to serve the mentally ill in the District of Columbia. In fact, over the years, the hospital has become increasingly a mental health provider to the District with 85% of the inpatient population now being District residents and nearly all of the outpatients served by the hospital and the Area D Community Mental Health Center being from the District. Thus, Saint Elizabeths Hospital has become an integral part of the District's public mental health delivery system. Any action by the federal government to close the hospital or to significantly reduce the resources available to the hospital would be regarded as a breach of a long standing federal commitment to the citizens of the District of Columbia.

In fiscal 1981, Saint Elizabeths Hospital had over 5000 admissions to inpatient status. There were increases in both new admissions and readmissions to the hospital, resulting in an overall increase of admissions from the prior year. Saint Elizabeths Hospital is the only psychiatric facility in the District of Columbia obligated to take patients without regard to ability to pay. In addition, Saint Elizabeths Hospital is the only facility mandated by statute to accept involuntary court commitments.

Thus, Saint Elizabeths performs a unique role in the mental health delivery system of the District of Columbia. The question that I would like to pose today is whether the functions of Saint Elizabeths Hospital could possibly be absorbed in the District's mental health system at the present time? I believe that the answer is no.

Saint Elizabeths Hospital is operating 1900 to 2000 beds of which 350 are for forensic psychiatry; 60 are for children and youth and the remaining beds are for adults in need of acute psychiatric hospitalization. On any given day 85% of these beds are filled by District residents.

There are only 506 other psychiatric care beds in Washington. Of these, 120 are for veterans and 201 beds are exclusively for private paying patients. Thus, private sector beds that are available to indigent District residents number only 185. In the period January through June of 1981, 85% of these beds were occupied, leaving only 27 beds empty and available at any given point in time. Thus, there is a real question as to where the patients who are presently hospitalized at Saint Elizabeths would be placed, if the hospital were to close.

As you are all well aware, there are a considerable number of inpatients at Saint Elizabeths Hospital who are candidates for outplacement under the Dixon Deinstitutionalization court order. As of October 1981 for example, there were some 357 patients identified as needing nursing home care. But I would point out that there are no available nursing level beds in the District of Columbia for these patients to move into en mass. While two facilities are expected to open in 1982, supplying an additional 380 beds to District residents, it is likely that only a few of these beds will be available for Saint Elizabeths patients. The court in approving the deinstitutionalization implementation plan recognized the acute shortage of nursing bed capacity in the District by allowing for the orderly outplacement of these patients between non and December 31, 1985. In light of the limited supply of nursing care beds presently available, I would pose the question where would those Saint Elizabeths patients go, who are in need of long term care, if the hospital closed?

This same line of questions can be applied to the forensic population, as there are not 350 beds in maximum and minimum security units in this city to care for

these patients. Nor are there 60 empty beds for the acute psychiatric hospital care of children and youth. In summary, this city needs the resource of inpatient beds that Saint Elizabeths Hospital offers and we are likely to continue to need a substantial number of these beds for years to come.

Saint Elizabeths Hospital is also a major provider of outpatient care. Area D Community Mental Health Center located on the grounds of Saint Elizabeths Hospital serves the residents of Washington living east of the Anacostia River. Close to some 3000 persons were served by the CMHC and offered over 12,000 hours of outpatient mental health services in the later half of 1981. In addition there are 1800 persons on convalescent outpatient status from Saint Elizabeths Hospital. These patients return to the hospital for their therapy, medication and other medical, social or vocational rehabilitation services. On the average during fiscal year 1981, each outpatient received forty hours of service from the hospital. While the Dixon Implementation Plan envisions the transfer of the convalescent leave patients who live in the geographic areas served by the District's community mental health centers, there are no plans for the District to assume responsibility for the Area D Catchment Population. The continued need and presence of Area D is evident in Southeast Washington.

I would also emphasize today that the Dixon Implementation Plan requires the orderly outplacement of inpatients to the community and the orderly transfer of outpatients to the District's community mental health centers. Any action taken that violates the terms of the court mandated outplacement plan will be met with appropriate action by the District to prevent dumping of patients into our community. I believe that the continued presence of Saint Elizabeths Hospital in the District's public mental health delivery system is essential for many years to come.

Alice T. Dodge, A.C.S.W.

It was with a sense of dismay and incredulity that I read the report in the Washington Post (December 3, 1981) that OMB had submitted to the Congress a proposal to delete from the 1983 Budget of the Department of Health and Human Services the item for the Federal portion of the cost of running St. Elizabeths Hospital. It should be obvious that the D.C. Government would not be able, within a year, to pick up the total cost of care of the 2,000 patients now in the hospital. Let alone carry out the necessary planning and financing to provide resources for them in the community. In other words, close St. Elizabeths Hospital, and let the patients fend for themselves as best they can!

As a social worker employed by the hospital for nearly fifteen years, ending in 1964, I know intimately the programs of the hospital at that time -- its benefits to patients and their families as well as its shortcomings. At the time I worked there, under the late Dr. Overholser, and subsequent superintendents, the tenet established by Dr. William A. White still held -- patient care takes first priority, the patient comes first. I can bear witness to the compassionate care and skilled therapeutic treatment methods provided by hundreds of dedicated personnel of all disciplines. I can also report many deficiencies. But St. Elizabeths Hospital at that time carried world-wide recognition as a model of patient care as against the notorious conditions then prevailing in most publicly supported mental hospitals. During that period, among other specialized functions, the hospital provided a highly efficient and compassionate program for hundreds of War veterans who broke down in combat and were sent to the hospital as a first step toward return to their home communities. Recent years have brought changes in the administration of the hospital, and reportedly a lowering of standards, resulting in temporary loss of accreditation. But I can state from first hand experience that there still remain in the hospital many sound therapeutic programs.

New knowledge is steadily being developed about mental illness, its nature, causes, and treatment ranging from drugs to intensive psychotherapy. There is much that we still do not understand. But the occurrence of mental and emotional disturbances in a large percentage of our population is a fact that won't go away.

For many patients, some now in the hospital, care and treatment in an appropriate community setting is preferable to hospitalization. Possibly large mental hospitals have served their purpose and their time has come. My own conviction is that for many people suffering from acute disturbances, such as psychotic breaks from reality, suicidal or homicidal tendencies, brief periods of hospitalization

provide essential protection and relief from the stresses of outside life, as well as an opportunity for a period of intensive care and skilled treatment which is difficult to provide in a community setting. There are also some patients whose deteriorated condition (only too often the result of long hospitalization) requires that they continue to have a degree of protection in community settings.

The real issue is not the sudden closing down of mental hospitals. It is how to plan and finance an appropriate continuum of community programs which would include various kinds of living arrangements, rehabilitation and training facilities and self-help programs (such as our own local highly successful Green Door) and of course medical and psychiatric treatment programs, including the availability of brief periods of inpatient care. Such planning and programs are enormously expensive and extremely difficult to carry out. There is some question whether adequate community care is less expensive than hospital care. But without such planning, too-precipitous release of patients from hospitals can result in the kinds of human tragedies we see in states like New York and the President's own California where large numbers of former patients live in pitifully inadequate residences, receive little or no medical follow-up, and frequently live literally on the streets.

In the District we may have averted some of this kind of disaster by embarking on programs, under the pressure of the so-called "Dixon Decision," to establish an appropriate network of community programs and services. Another action currently under way is joint planning by the D.C. Government to consolidate the programs of the D.C. Mental Health Services Administration and the Hospital under an overall Corporation. Meanwhile patients are being discharged without adequate planning (witness the so-called "street people" and the fire in a residence where several patients were burned to death). The D.C. mental health clinics, under steadily reduced financing, are finding it increasingly difficult to take up the lead; residential facilities are overflowing.

In light of these realities, the OMB proposal sounds like an absurdity. We can hope that it is, that Mr. Stockman was only using it as a way to "prod" the authorities into action. We can hope "it can't happen here." But in view of what has already "happened here" at the hands of the budget cutters, it behooves all of us as citizens to join together in demands that sanity, not ruthlessness shall prevail in planning for St. Elizabeths Hospital. There may be an opportunity here for us to demonstrate a new and creative approach to this problem; let it not be thwarted by the zeal to save money, even at the expenses of human lives and suffering. Perhaps the most devastating aspect of the report is that there was no evidence that OMB took into account any planning and thinking that is already going forward in this area.

REVEREND GEORGE A. FIELDS

If St. Elizabeths Hospital was to close, this would have a personal affect on me. I have a family member who has been a patient there for a long time. Where would the patients be housed? I think St. Elizabeths Hospital should remain open and the necessary improvements at the hospital be put into effect. Some of those improvements, to name a few, would include new and better methods which could aid in the healing of the mentally ill, more and better recreational facilities and to hire more qualified dedicated employees. Keeping St. Elizabeths Hospital open and making the necessary improvements would put the hospital's reputation into a "new light," therefore benefitting the staff, patients, family members and of course, the community.

FELICIA A. LIGHTFOOT, ASSOCIATE DIRECTOR, AND MEMBERS
GREEN DOOR

The members and staff of the Green Door urgently petition the Reagan Administration to evaluate and reconsider its proposal to close down St. Elizabeths Hospital. We offer instead the recommendation that the Administration sanction the Dixon Plan. We believe that the Dixon Plan would better assist the Administration in achieving its goal to reduce Federal spending in the human services arena in a way that would mitigate against panic and hardship on the residents of Washington, D.C.

The Dixon Plan has been widely accepted by the citizens of this city as the best possible way to deinstitutionalize large numbers of St. Elizabeths Hospital patients. St. Elizabeths Hospital, the District of Columbia Government, and the Federal Government are under court mandate to place approximately 1,300 hospital patients in the community by October 1, 1982. Completion of this plan will undoubtedly make hospital services more cost-effective and humane. The process has been a slow and arduous one, but there are strong commitments from private community agencies to meet this challenge in a positive, orderly and humane way. St. Elizabeths Hospital and the District Government should be commended for the progress made thus far.

The Administration's proposal to shut down St. Elizabeths Hospital implies that the Federal Government wishes to absolve its responsibility to the court mandate. This is truly unfortunate as well as untimely since it robs the District residents of an opportunity to actualize their goal in meeting the mental health problems of this city. We all need to feel that we have some control in rectifying crucial human problems.

In announcing the proposed shut down of St. Elizabeths Hospital, there was no discussion as to why this plan and not another; or what would be the cost in terms of human lives. From our vantage point it appears that the Federal Government wants to take care of the problem without any input from those persons directly affected. Can the residents of this city be assured that the Administration will also take care of the solution in a humane way? There is no other public inpatient mental health facility in this city. Where will those of us who occasionally need inpatient care go for service? Most of them cannot afford to purchase these services in the marketplace due to fixed incomes.

Final court approval of the Dixon Plan indicates an explicit assurance from St. Elizabeths Hospital and the District of Columbia of responsiveness to the mental health needs of its residents. We believe that this supports the Administration's edict to make the states more responsible for human services.

The Dixon Plan was not conceived by the Reagan Administration, but it can be an effective plan irregardless if allowed to be completed. We implore this administration to give the District this chance to prove the plan effective in reducing Federal spending for St. Elizabeths Hospital without producing a deficit in human terms.

In closing, we would like to thank the Mental Health Association of the District of Columbia for providing a forum for District residents and community agencies to express their concerns regarding the disposition of St. Elizabeths Hospital.

MARY HAUPTMAN

I think that disposition of the patients presentedly treated at St. Elizabeths should be according to the nature of their psychiatric needs, and that the patients can be divided into roughly three groups:

- A. the criminally insane
- B. the treatable (by conventional psychiatric treatment)
- D. the others, many of whom are primarily in need of social support and some type of sheltered living arrangements

My recommendation is that St. Elizabeths should be converted to a shelter and low cost housing facility to serve the needs of the patients described in "others" at minimal cost and also the needs of many residents of the community at large, whose needs for low cost supportive housing must be met if more costly forms of institutionalization are to be avoided.

The "treatable" should be transferred to another psychiatric facility to be given the full treatment their potential deserves. Ideally such a facility should be the first in the nation to be set up as a true holistic mental health treatment center, substituting alternative therapies for the standard chemical drug treatments.

The "criminally insane" should be treated within a prison setting and the psychiatric facilities made available on an outpatient basis to the general prison population and to their families.

REVEREND ANNIE WOODRIDGE
MOTHER DEAR COMMUNITY CENTER

I am sure that all of us who are here today realize the importance of maintaining St. Elizabeths Hospital to continue mental health services to the constituency of the District of Columbia. Through its institutional facilities. It is important to point up that we have complete neighborhood services with satellite outreach teams located in different areas of the city basic services are provided and are available at centralized locations, after care is provided to support patients returning to the community from various institutions. This network of agencies and individuals are working together to improve the quality of life for long-term mentally disabled patients, these community services fit the needs of clients so that they can enjoy community living without exclusion and isolation. This is all good and well but what about those who are chronically ill? If St. Elizabeth is closed who will address themselves to those who are in dire need of immediate emergency help after the community based programs are closed? If we have other hospitals in the area but they are not able to cope with all of the cases that come in daily in housing these persons. Outreach programs and consultation programs along with prevention programs are necessary, but here is still an institution such as St. Elizabeth needed to cope with those astronomical groups of persons who are in need of chronic inpatient care. Service commitment to chronically mentally ill patients is the responsibility of an institution such as St. Elizabeth Hospital that has the expertise, responsibility, accountability responsiveness to the constituency of our Nation's capital. St. Elizabeth is equipped to treat the patient, mentally and physically, why should those who cannot help themselves be deprived of this resource? Basic needs will not be met. Proper medical treatment in dire emergencies will be denied, a process of extensive planning training, and work will have to become relevant to take on the massive assignment of treatment in a most efficient way if this dynamic institution is closed.

It is only after a patient has been treated in such a setting being chronically mentally ill and properly evaluated and it is fully determined that he or she is not a threat to society or himself that he should be deinstitutionalized so that the event that occurred on 14th and Randolph Streets will not be repeated. Again I emphasize keeping the doors of St. Elizabeth opened for the good of those who are in need of its services and for the safety of those who walk the streets daily.

EMMA R. MCGRAW, VICE PRESIDENT
NATIONAL ASSOCIATION OF BLACK SOCIAL WORKERS, METROPOLITAN WASHINGTON CHAPTER

On behalf of the Metropolitan Washington Chapter of the National Association of Black Social Workers, I wish to convey the concerns of our membership about the curtailment and possible closing of St. Elizabeths Hospital. As a non-profit, voluntary association of Black human service professionals, we have a special sensitivity to people in need as well as the professional training and, in some instances, clinical qualifications to help others work through crises. Therefore, St. Elizabeths and other social service agencies in the Metropolitan area are no strangers to us.

Over the past few years, we have anxiously observed the releases of hundreds of patients with only temporary mental competency levels return to a community that was unprepared to provide the necessary supports for their self-sufficiency. The results have spelled disaster and the explanation given was "budgetary constraints." It is with pleasure that our organization has been afforded this opportunity to voice our concerns about the plight of these former patients as well as speculate on the impact of no facility. St. Elizabeths has played a major role in providing services to the mentally afflicted of the Metropolitan Washington Area. Their nutritional programs, medical services, therapy sessions, and housing accommodations are unsurpassed. It is most disheartening to think of the many homeless, former patients of St. Elizabeths who now wander the streets of the District, braving the trials and tribulations of life on a day-to-day basis while buildings sit empty at St. Elizabeths and its staff are deployed due to funding losses.

The Metropolitan Washington Chapter of the National Association of Black Social Workers urges the immediate reconsideration of the closing and further curtailment of St. Elizabeths. We are convinced that a random sampling of former patients' functionality in the community today would provide startling evidence for the facility's continued and probably, its expanded operation. Thank you.

CYNTHIA ROBERSON, EXECUTIVE DIRECTOR
NATIONAL ASSOCIATION OF SOCIAL WORKERS

Good afternoon. I am Cynthia Roberson, Executive Director of the Metropolitan Washington Chapter of the National Association of Social Workers.

Before beginning, I would like to extend my congratulations and appreciation to the Mental Health Association of the District of Columbia. Your decision to sponsor this hearing on the possible closing or curtailment of services at St. Elizabeth's Hospital is a serious response to what, we are certain, is a serious proposal from the Office of Management and Budget.

When the public was first informed of this proposal by way of the public media, many of us thought it could not be true - this was another trial balloon; another effort to formulate social policy through press releases. Upon reflection, we must accept the fact that it is probably very true and likely to happen in the near future. After all, this is the administration which was willing to accept the designation of ketchup as a vegetable; willing to give states additional control over monies and programs while cutting the states' amount of federal revenues for these same programs; willing to cut social security benefits for the population most in need of that income and very recently, the administration which is willing to use tax dollars to fund segregated education.

One fact which has become clear this past year is that the Reagan administration is not only a new administration but a social revolution. We are viewing a return to the philosophy that everyone should and must become self-sufficient. The philosophy which sees people, in need and want, as inherently weak. In this environment, a proposal which would have been considered an object of amusement in the past becomes a matter of major concern. For if this is another attempt to provide benefits only for the "truly needy," then we are about to witness a return, in the District, to a mental health facility which provides custodial care, rather than a therapeutic setting.

To propose closing a federal installation which provides the major public portion of both in-patient and out-patient services for mentally-ill individuals in a major city with a population of more than 600,000 is an act both ill-advised and cruel. To propose it as a budget-cutting action displays an unwarranted disregard for general public welfare. Facing the same federal cuts as other states, the District of Columbia does not have the financial wherewithal to assume the operation of St. Elizabeth's. Given the fact that alternative public facilities are not available, one must look to private facilities. According to your statistics, approximately 2,200 D. C. residents have been admitted to private facilities, profit and non-profit in the past year. We might assume those facilities are at or near capacity levels. As fact we need not assume is that those facilities are paid through insurance plans or private funds.

Consideration must be given to both in-patient and out-patient services provided by St. Elizabeth's. Apart from in-patient services, the staff of St. Elizabeth's, especially the social work staff, provides out-patient services. Of a patient roll with approximately 5,000 patients, 3,000 are out-patients. This means that St. Elizabeth's is providing services to people in the community as well as those hospitalized. Social work staff monitors almost 600 patients living in community residential facilities. The facilities where the patients live must be licensed and the personnel of those facilities must be trained. As of September, 1981, there were approximately 160 such homes in the District, which are being monitored by social work personnel from St. Elizabeth's.

Social work staff is also responsible for nursing homes placements and monitoring those who are still patients of St. Elizabeth's. In preparation for nursing home placements, the clients are engaged in a special program. Once clients have been placed, the social workers are available for consultations with nursing homes staff.

There are other areas of involvement when patients are discharged into the community or preparing to be discharged. For example: Social workers coordinate all activities around placement in Section 8 Housing; they collaborate with those agencies providing transitional services for former patients; community-based groups for both in-patients and out-patients are conducted in order, gradually, to socialize them into community settings; and last, but not least, all the activities around acquiring, retaining, or terminating financial assistance for eligible

patients are handled by social workers. Typically, social workers provide the major link between the patients and other societal institutions.

The preceding activities are especially important to the District of Columbia in light of the Dixon degree. It has been demonstrated that deinstitutionalization is truly successful only when community support systems are available and functioning. Also, there must be some linkage between the mental health institution and the community support systems.

I mentioned earlier the lack of public alternative facilities. This is especially important in light of an action taken by the District last October. The Department of Human Services closed its children and adolescents in-patient psychiatric units with the understanding that the majority of those children and youth in need of hospitalization would be sent to St. Elizabeth's. Included among the reasons for that decision was to provide an expanded day-treatment program and other out-patient services. Thus, while the federal government is discussing terminating or curtailing services, the District government has already eliminated one alternative.

I have spoken of out-patient services provided by social workers at St. Elizabeth's. This is not, however, the only role social workers play at St. Elizabeth's. They also serve on the primary treatment team for in-patient services, often functioning as the team leader. They are involved in individual, family, and group therapy. In addition to serving as the major linkage with the patient's family.

It is difficult to speak of the future, when the present and immediate future look so gloomy. However, St. Elizabeth's also serves as a training site for future mental health professionals. Locally, social work graduate students from Howard and Catholic Universities receive field instruction at the hospital. This provides 35 students each year with the opportunity to work and learn at a major institution. The training of psychiatric social workers continues a field of social work practice which dates back to the early years of this century.

Today has given me the opportunity to see this field of social welfare in microcosm. Earlier, I was at Howard's School of Social Work to talk with Bachelor of Social Work (B.S.W.) students; this evening I will be meeting with the Chapter's Social Issues Committee. Those two activities combined with this, help me to focus on some very important realities. There are and will be people in need; there are and will be people who hope to provide services to those in need; and finally, there are processes whereby public policy which would deny services to those in need can be affected.

I am pleased to have been invited to participate in this process.

CAROLE SCHAUER, EXECUTIVE DIRECTOR
NATIONAL HEALTH CARE FOUNDATION FOR THE DEAF

The National Health Care Foundation for the Deaf is a non-profit organization in the District of Columbia, that operates Otis House, a Licensed Community Residence Facility for deaf adults with emotional and social adjustment problems and in need of learning independent living skills. This Spring we will also be opening CHHI (key) House, a new six bedroom physically accessible home. It will be an independent living facility for chronically psychiatrically disabled deaf adults. CHHI House is funded through a 202 loan from the Department of Housing and Urban Development. We thank you for this opportunity to share our concerns at today's meeting.

Our concern is with deaf persons in the District of Columbia who are in need of mental health services. Deafness is a handicap of communication. Therefore, it is uniquely different than any other physical handicap. Few, if any, handicaps prevent communication as overwhelmingly and with such impact as deafness. Deaf persons as a group can, paradoxically, be either the most handicapped or the least, depending on how the environment has responded to them and their handicap. Generally, deaf persons experience more inadequate and inappropriate education and more limited vocational opportunities.

The provision of Mental Health Services must be especially geared to the deaf person's needs. Critical to effective rendering of services is the communication mode. Most deaf persons use a unique manual language, American Sign Language. This language uses signs and fingerspelling for communication. It is unlike

English in that it has its own syntax and structure. Deaf persons also use special devices in their homes and work places to accommodate their hearing losses. These include blinking lights for doorbells, telephones and smoke detection equipment, teletypewriters for telephones (like the one displayed) and decoders for television.

The special nature of deafness requires fluency in sign language, as well as special knowledge and skills related to deafness, by those providing services, if the services are to be effective. First, service providers must communicate effectively by using sign language, especially with the "low verbal" deaf persons. "Low verbal" refers to deaf persons with minimal English language, either spoken, written or signed. These persons require American Sign Language skills that are rare among service providers or professionals. Second, service providers must be knowledgeable about psycho-social-cultural aspects of deafness. The simple provision of an interpreter does not necessarily make a service accessible to the deaf person. Personnel of all levels require special training. Third, facilities providing service must utilize typewriters for telephones so deaf persons have access to the facility.

The National Census of the Deaf Population conducted in 1976 revealed that 49,000 hearing impaired persons live in the District of Columbia. Of that group, 6,800 were identified as deaf. Research has demonstrated that deaf persons generally have the same rate of mental illness as the hearing population. Therefore, based on the commonly used estimate of ten percent, 650 deaf persons in the District need mental health services. If the fifteen percent figure is used as identified by the President's Commission on Mental Health in 1978, then 975 deaf persons need some form of mental health services at any given time.

Presently, the Mental Health Program for the Deaf at St. Elizabeths Hospital provides the services of a 40 bed inpatient unit for deaf adults and adolescents. This unit is one of about 20 inpatient programs in the whole United States for deaf persons and is the only one in the metropolitan D.C. area. This unit serves Washington, D.C. as well as the nation. It also operates an outpatient service. Our agency receives most of our referrals from this program, and our clients receive medical and psychiatric support services from this program.

Currently within the D.C. mental health system, a deplorable situation exists. Not one Community Mental Health Center in the city can provide any mental health services for deaf adults and children, including evaluation, individual group and family therapy, case management, and crisis intervention, including phone-in and walk-in contact. D.C. has long denied deaf persons equal access to mental health services.

Therefore, to address the issue for today's hearing, if St. Elizabeths is closed, and this includes the closing of the Mental Health Program for the Deaf, a crisis will result because of the lack of mental health services for the deaf in the city. D.C. must then make provision within its mental health system to provide a continuum of services, including inpatient services and those defined in the Dixon Standards, for its deaf citizens. In actuality, whether or not St. Elizabeths closes, D.C. should presently be providing those services. Deaf persons are entitled by law to equal access of mental health services from the District of Columbia. Section 504 of the Vocational Rehabilitation Act of 1973 emphasizes the right of deaf persons to such services.

Although I am advocate of deinstitutionalization, I encourage that very careful consideration be given to the disposition of the deaf program. Since physically handicapped persons and especially the deaf are often the last to be provided mental health services, we are concerned that this group would again be the last to be considered if St. Elizabeths were closed. Closing it without the careful planning for provision of alternatives would be a disaster. It would seem logical that deaf consumers and local agencies providing services to deaf persons would be called upon to share their opinions and needs in this matter, and that those in command who wield such power would not simply drop the axe because it is financially expedient to do so.

REVEREND JACK E. McCLENDON, ASSOCIATE MINISTER
NEW YORK AVENUE PRESBYTERIAN CHURCH

Senator William Proxmire should give David Stockman the Golden Fleece award, an award which he hands out to the government agency that dreams up wasteful studies and vast expenditures of public funds for the most non-sensical projects. Surely Mr. Stockman proposal to close St. Elizabeths Hospital would place an enormous burden on an already over-taxed mental health system in the District of Columbia. If OMB considers closing the hospital as a money saving device, they surely have not examined what chaos that would cause in the District of Columbia. Neither the D. C. Government nor private mental health clinics can possibly absorb 2500 patients from the hospital. If approximately 50% of the homeless persons in our community are former patients of the hospital, then that number will increase astronomically if the hospital is closed. The city shelters and the private run shelters for the homeless (in churches and former homes for Nuns) are already overtaxed.

Such a proposal to close the hospital is unconscionable, insensitive and downright absurd. More thought should be given to the proposal to create a "Public Corporation" to adequately run the two mental health systems in existence, St. Elizabeth's and the Mental Health Administration. The two systems presently collide and many desperately needy persons fall through the cracks. If the hospital is closed, neither the public or the private sector can possibly meet the needs of the patients who would be turned out on the streets.

GWENDOLYN MCPHAUL, M.A.
POTOMAC ART THERAPY ASSOCIATION

As a representative of the Potomac Art Therapy Association, I would like to express our strong opposition to the closing or curtailing of services at St. Elizabeths Hospital. Art Therapy is a non-verbal means of communication and a non-threatening mode of expressing one's inner feelings, and is a strong positive therapeutic tool at St. Elizabeths. It offers on-going therapy for the patients there, who in many other settings may be left to deteriorate because of staff's inability to work with them. St. Elizabeths offers a structured environment for those who cannot possibly be self sufficient in the community. St. Elizabeths offers a therapeutic system for the patients.

Another very important factor is that St. Elizabeths is a teaching facility. Students assigned there gain a great deal from the staff and most of all the patients. Along with this, the patients are given the freshness of the students who are eager to learn and utilize their developing skills. Hence, services are provided for all those at St. Elizabeths who can benefit from someone working with them.

As a person who works in a Community Mental Health Center in Maryland, I can also say that the Community Mental Health Centers are not equipped nor prepared to handle the large numbers of chronic people who would become the deinstitutionalized people of this area. Then, what happens to these people who need more than a day treatment setting? Where will they live? What structure will replace the secure environment which St. Elizabeths provides for them? What preparatory measures will they be given before St. Elizabeths has to close? What support system will be there to rejuvenate the staffs of the Community Mental Health Centers, who will be overtaxed with the abundance of chronic long-term and suddenly deinstitutionalized patients?

Finally, speaking as a resident of the District of Columbia, I am concerned about the residents of St. Elizabeths, who would become the helpless individuals of our community. Will there be adequate food and clothing? Will there be proper housing or will more deinstitutionalized patients of St. Elizabeths, who have been pushed into the community, perish in fires (which has happened in the past), or freeze to death on the streets of the nation's capitol? I feel that if St. Elizabeths Hospital is closed and its residents are turned out into the unfamiliar quarters of the community, it would be a very frightening and inhumane act.

I strongly feel that St. Elizabeths should be kept open to continue the greatly needed services that it provides for our community.

JOSEPH SMITH, M.D., PRESIDENT
ST. ELIZABETHS HOSPITAL PHYSICIANS' ASSOCIATION

1. The mentally ill have been a public responsibility since ancient times.
2. The moral standards of a society are most clearly reflected by the care provided for those unable to care for themselves, including the mentally ill.
3. We believe that the citizens of the District of Columbia are entitled to adequate care for their mentally ill, and that an adequately funded and administered psychiatric hospital is essential to that care. Until another facility is provided, St. Elizabeths is needed.

JOHN H. BURNS, ADMINISTRATIVE DIRECTOR
TENTH STREET BAPTIST CHURCH COMMUNITY RESIDENCE

The Pastor and the Congregation of the Tenth Street Baptist Church, owners and operators of the Tenth Street Baptist Church Community Residential Facilities, located at 2109 R Street, S.E., Washington, D.C. are appalled at the proposal from the Director of OMB, Mr. David Stockman, concerning the closing of St. Elizabeths Hospital.

Since our inception we have been associated with the staff and patients of the above named hospital; many of our residents are from this institution.

While we would be one of the first to admit that the institution and its staff have some shortcomings, we find that their interest and cooperation for their patients are better than any other entity that we deal with throughout the Metropolitan Area.

We find that the staff is superb in following up on the conditions of their patients, which our contract calls for. For example: if a patient should become ill or if death should occur the social workers are as near as the telephone. They also check on their diets, medications, personal hygiene and are most attentive in seeing that their monies are handled properly.

It seems to us that OMB wants to retrogress rather than progress, and this is just what this proposal suggests to us. We would suggest that OMB set up a task force with the operators of all CRF facilities, to explore this proposal before this drastic proposal is put into action.

After all we feel if the hospital is closed the patients will suffer greatly.

Where will they go?

We also think that this proposal will put added burdens upon the operators who are already over worked and under paid.

In closing, we would like to ask Mr. Stockman or a representative to appear at a hearing with the Mental Health Association and all who are concerned at a future date, whereby we might be able to question him about his proposal in more detail.

JOHN COLBERT, VICE PRESIDENT
THRESHOLD OF THE DISTRICT OF COLUMBIA, INC.

For those of you who have not heard of Threshold - DC, we are a self-help group of families and friends of the mentally ill. We made our debut in April 1981. Threshold - Montgomery County has been in operation nearly four years and Prince George's County founded its group this past October. There are quite a few family groups which have been operating for several years and many others are forming throughout the nation because conditions surrounding mental illness are so devastating. Our group and most of the others are affiliated with the National Alliance for the Mentally Ill which has headquarters here in Washington, D. C.

From the moment the news was received that the OMB had proposed the possibility of closing St. Elizabeth's Hospital, we remarked that "even the thought was ridiculous since no solution was offered for the problems which this action would impose."

We would like to see SEH continue as a Federal facility for several reasons. Firstly, contrary to public opinion, it is widely used by a number of citizens from other jurisdictions as well as foreign nationals who are clearly not the responsibility of the District Government. All of the aforementioned persons are evidently in need of services and care which for some reason cannot be provided in their home districts. Secondly, it is extremely unlikely that the D.C. Government can afford to assume total responsibility for this facility. It would be disastrous for the District of Columbia to take on this financial burden at a time when the city is having to reduce spending because of cut-backs in funding. The fact that the Federal facility has repeatedly lost its accreditation is proof of a troubled situation and that in itself would call for additional spending.

The question that all concerned families and citizens are asking is, "WHERE WILL PATIENTS GO?" If this question could be satisfactorily answered, then we do not have a problem. All of us need certain basic life-sustaining items such as food, shelter and clothing. How would these items for 2,000 in-patients be obtained and where would 3,000 out-patients receive treatment? All of these patients need medical and various support services, but there is very little presently available in the community. In Threshold, we contend that there is need for a greater sense of human right from our officials and providers. How much is the human being worth in this society? Bombs and missiles seem to be worth a lot more.

If SEH is closed it would create a most critical situation in this city and the surrounding area. There would be a great many more individuals thrown to the streets with no sense of direction who would surely deteriorate or be destroyed by corrupt forces in the society. With the poor quality of services at SEH most patients would leave on their own if they could do better; therefore, the focus must be on improving and upgrading the quality of services, not abolishing them.

The nature of the illness often gets the patient tangled-up in the criminal justice system. Crime on the street will be more prevalent with more patients on the streets who are not in the state of mind to be responsible for their acts or to protect themselves from being victimized. One example is the senseless shooting which occurred on New Year's Day. The family bears a tremendous emotional and financial burden in addition to the load of this catastrophic illness. Every time the phone rings, families wonder if it is the police who may tell them that their loved one is sleeping in the gutter, wandering in the middle of the road, trespassing to get warm, getting into fights or just plain disturbing the peace. Families are not equipped to take care of and treat their chronic mentally ill members. Half-way houses and nursing homes are inadequate and almost nonexistent. That leaves the streets of our communities which can least deal with the problem.

It appears that the OMB is saying, anyplace but here. Families invite the OMB to tell us where.

KATHY MAGUIRE, DIRECTOR OF SOCIAL ACTION & ADVOCACY
WASHINGTON AREA COUNCIL ON ALCOHOLISM AND DRUG ABUSE

My name is Kathy Maguire. I am the Director of Social Action and am speaking on behalf of the Washington Area Council on Alcoholism and Drug Abuse.

St. Elizabeths has always been a significant Federal institution. It is a showpiece, a model for the nation; as such it benefits the entire country. A Federal presence in this hospital is integral to maintaining the numerous achievements that have resulted and need to be on-going.

St. Elizabeths has repeatedly proven to be a model for the country through its leadership, training and research components. Under the direction of Superintendent Luther Robinson the hospital was a pioneer in the addiction field. Here was initiated one of the first programs for alcoholism treatment, which incorporated the use of Alcoholics Anonymous. The alcoholism and drug programs at St. Elizabeths are among the best in the District of Columbia, public or private.

St. Elizabeths also has a model mental health program for the deaf. The hospital has continued this quality commitment throughout its history in the aforementioned areas.

This has led to exemplary programs for the community at St. Elizabeths' alcoholism treatment programs, and later in drug abuse, i.e. the Last Renaissance.

The Community Mental Health Center is still a leading light for a model to follow as its drug and alcohol programs are excellent examples for the private sector.

Rather than dismantling St. Elizabeths, there should be analysis to find out what they are doing at the hospital that works and is so effective.

The already existing problems of the homeless are critical in this city. Putting more people into the community will only exacerbate this dilemma. The remainder of persons residing in the hospital are not prepared, nor is the community prepared to house and provide resources for the displaced hospital patients.

Note should be made of New York City and the present crisis they face with the homeless and lack of mental health care centers. This situation is similar to what the nation's Capital will undergo if the hospital's services are curtailed.

At the very least, a lengthy transition with considerable planning must be ensured for these persons presently in the hospital and for the community's resources. The thought of loss of the hospital's services is staggering to the alcohol and drug community, and we strongly oppose such a step. The community would lose a great service, leadership training and research facility, which is already unable to meet the needs of the community in the addiction area.

PAULA MAURICE, CONSUMER
WOODLEY HOUSE

I am Paula Maurice an out-patient at St. Elizabeths Hospital and I am presently living at Woodley House, a psychiatric halfway house that has served the District of Columbia for 24 years. I represent myself and Woodley House.

We at Woodley House are concerned about the quality of treatment at St. Elizabeths and the deinstitutionalization process as patients leave the hospital. We are not against hospitals, we are for effective treatment inside and outside of hospitals. What we are against is institutionalization and the handicapping effects it has on human beings.

I am here to say that during my 3 months stay at St. Elizabeths, on O'Malley Division, my immediate crisis needs were met on the admission ward and within that 1-1/2 months time there. The social worker and student intern began to plan with me my next step and they suggested that I call Woodley House. I can personally report the following review of my treatment plan which I consider as life saving during my short stay at St. Elizabeths. I would be concerned if this form of devoted care and treatment in the admission ward would not be available to others who follow me.

From the first kindnesses during the admission procedure to the kindly manner in which nurses and technicians acted as I was assigned to the ward, the care was personal and showed understanding and warmth. The doctors were competent and encouraging, the medical students interested. Dance therapy was excellent; occupational therapy gave a real sense of accomplishment; recreational therapy provided fun, exercise and challenging activities in the out-of-doors. Family conference was a crucial tool in my recovery. Group psychotherapy, under the direction of the physicians and also encouragement of small groups run by patients were a tremendous aid in health care during my later experience on the regular ward. Among other reasons, because it gave patients the chance to share their problems and to see that others had similar problems and experience. Assistance by the social work staff helped me in many ways, including locating a half-way house, Woodley House. Industrial therapy has started me on a whole new career in the greenhouse. This program of paid employment can assist a person in finding a new self-respect, in learning new skills and in establishing working relationships with co-workers and supervisory staff. The book and periodical and record circulating library was a source of intense enjoyment for me.

St. Elizabeths Hospital provides these and other outstanding services to the community. My own experience has shown me how much it can do to contribute to the health of those who need it. I beg you to consider the very real need that so many of us have at St. Elizabeths Hospital.

The Board and staff at Woodley are concerned about the planning process of any change, whether it is reduction of in-patient services under the OMB or the elimination of the dual delivery system through the corporation plan. If these plans are based only on budgetary and cost-effectiveness needs and without planning for quality of services, coordinated with the private and public sector, then deinstitutionalization under the Dixon Plan will fail as it has in other large urban areas. Woodley House and its residents, who have used St. Elizabeths effectively, would like to be counted as an organization that is concerned about the OMB's proposal to close or curtail services at St. Elizabeths. We will be watching and listening for any announcements and we are willing to serve on any planning committees that will be proposing such a plan.

I am pleased to have this opportunity to express my concerns and the concerns of Woodley House.

SUMMARY

The following themes summarize the testimony from thirty-one individuals and groups, including D.C. Government officials, current and former St. Elizabeths Hospital (SEH) patients, employees, professional organizations, churches, community residential facility operators, community agencies, and concerned citizens:

- If SEH were closed - or if Federal support were reduced - local public and private agencies combined could not absorb the additional patients.
- SEH operates approximately 2,000 beds. There are only 500 other psychiatric beds in D.C., including 120 for veterans and 200 for private paying patients.
- A cutback at SEH will mean an increase in the homeless who wander the streets and an increase in human misery and social problems.
- The idea of precipitously closing SEH or cutting back on its services is "preposterous," "ridiculous," "reprehensible," "unconscionable," "unthinkable," "insensitive," "absurd," "ill-advised," and "cruel."
- The District Government could not possibly take over the financial responsibility of operating an institution with a \$120 million annual budget.
- The idea of cutting services or closing the hospital has no justification in political philosophy, treatment philosophy, or administrative philosophy; it is a crass attempt to save money for the Federal Government.
- There has been no consultation between OMB officials and District Government health and planning officials including Federally mandated citizen advisory bodies.
- The hospital provides vital and beneficial services; nevertheless, in some cases staffing is insufficient. Therefore, instead of reducing funding to the hospital, OMB ought to increase it.
- SEH provides vitally needed services for several special groups: those who cannot afford private care, the hearing-impaired, the "criminally insane," and children and youth.
- Closing down services at SEH cannot be justified by the need for deinstitutionalization. There already is a carefully worked out plan for deinstitutionalization mandated by the Federal courts, the Dixon Plan. And the OMB cuts would impede its implementation.

LETTER FROM POLLY SHACKLETON, CHAIRPERSON, COMMITTEE ON HUMAN SERVICES

Dr. Juliette Simmons
President
Mental Health Association of
the District of Columbia
2101 Sixteenth Street, N.W.
Washington, D.C. 20009

January 4, 1982

Dear Dr. Simmons:

I appreciate your invitation to participate in the Mental Health Association's community hearing on possible federal budget cuts for St. Elizabeth's Hospital. I will not be able to participate in the hearing, however, since the Committee on Human Services is currently reviewing the District's fiscal year 1983 budget and has its hearings scheduled for that week.

Furthermore, it is my understanding that the submission of President Reagan's budget to Congress has been postponed until February 9, 1982. Therefore I believe it would be difficult to formulate specific responses to St. Elizabeth's Hospital's program until we can review the President's proposals.

Since the Committee on Human Services is responsible for budget action on both the St. Elizabeth's payment and the Department of Human Services' budget, we will continue to monitor these developments.

Sincerely,

Polly Shackleton

POLLY SHACKLETON
Chairperson
Committee on Human Services

LETTER FROM WILLIAM H. DOBBS, M.D., SUPERINTENDENT, ST. ELIZABETHS HOSPITAL

Juliette Simmons, M.D.
President, Mental Health Association
of the District of Columbia
2101 Sixteenth Street, NW
Washington, D.C. 20009

December 30, 1981

Dear Dr. Simmons:

Thank you for your letter dated December 29, 1981, inviting my staff and I to testify at a community hearing on January 18 on the budget proposals for Saint Elizabeths Hospital. At the present, we are in the process of formulating the final budget and budget policy for Saint Elizabeths Hospital for fiscal year 1983. It would, therefore, be inappropriate for my staff or myself to make a public statement in advance of President Reagan's announcement of the proposed 1983 budget.

However, once the President has submitted the proposed 1983 budget to Congress, I would be pleased to discuss its contents at such a community meeting.

Sincerely yours,

William H. Dobbs, M.D.

William H. Dobbs, M.D.
Superintendent

REQUEST TO HEAR OTHER COMMUNITY WITNESSES

Senator SPECTER. I do not think any questions are really necessary. I think we have the sense of your testimony when you said that the proposal was preposterous, ridiculous, reprehensible, unconscionable, unthinkable, insensitive, absurd, ill-advised, and cruel.

I do not think you left anything out.

Mrs. SECUNDY. We perhaps said it to help you in providing data on the community facilities that are currently serving the mentally ill and the deficiencies in that area.

Senator SPECTER. We would like the additions as to what facilities are available in your judgment should this worst case scenario, as outlined by Dr. Mayer, come to pass.

Mrs. SECUNDY. We would like to provide that too.

Senator SPECTER. Thank you very much.

We have been requested to hear other community witnesses and notwithstanding our limited time, we have agreed for a few moments today to hear from Norman Rosenberg, the director of the Mental Health Law Project; Mr. John Connelly, staff attorney of the Information Center for Handicapped Individuals; and Mr. Clarence Martin, executive director of the Association for the Advancement of Psychology.

If you would step forward and, Mr. Rosenberger, we will hear from you first.

Any statement submitted will be made a part of the record.

MENTAL HEALTH LAW PROJECT

STATEMENT OF NORMAN ROSENBERG, DIRECTOR

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

STATEMENT OF CLARENCE MARTIN, EXECUTIVE DIRECTOR

COURT ORDERED CONTINUUM OF SERVICES

Mr. ROSENBERG. I have with me today Joseph Mannis. We are both employed by the Mental Health Law Project, which is a Washington, D.C., based public interest organization which, for more than a decade, has worked to improve the quality and availability of services for mentally ill and mentally retarded people, in institutions and in the community.

I am here today in my capacity as counsel to the plaintiffs in *Dixon v. Heckler and Barry*. This is a Federal Court lawsuit brought in 1974 with the goal of ending the unnecessary confinement of many of St. Elizabeths Hospital's patients and compelling the establishment of suitable programs and services for them in the District of Columbia.

In 1975, Federal District Court Judge Aubrey Robinson issued a landmark opinion in the *Dixon* case. In it he ordered the District and Federal governments jointly to plan for and create a continuum of services for current St. Elizabeths patients and those at risk for future hospitalization.

Not surprisingly, it has been exceedingly difficult to shift the focus of care from the hospital to the community and develop this continuum of services which was envisioned by the court. The obstacles to this process are exacerbated by the existence of two mental health systems in the District of Columbia—often serving the same clients but separately administered. St. Elizabeths Hospital is operated by the Federal Government and the community mental health centers are operated by the District's Mental Health Services Administration.

PANEL REPORTS

It would be less than candid to say that our goal of creating an integrated mental health system has been entirely successful. It has not. In fact, counsel for the *Dixon* plaintiffs have had to return to court several times, most recently requesting that the District's government be held in contempt and that a special master be appointed to oversee compliance with the court's mandate in *Dixon*. I have with me and, with your permission, would like to have included in the record of this hearing three reports by a panel of experts, documenting the serious inadequacies in the service delivery system for mentally ill people in the District of Columbia.

These reports show inadequate services, inadequate housing facilities, inadequate crisis resolution and other services critical to provide good effective mental health care to patients living in the District of Columbia.

Senator SPECTER. We will be glad to receive them.

[The information follows:]

RECOMMENDATIONS OF THE DIXON IMPLEMENTATION MONITORING COMMITTEE TO ACHIEVE
THE DISTRICT DEFENDANTS' COMPLIANCE WITH THE DIXON CONSENT ORDER

I. INTRODUCTION

September 30, 1982

As a result of its review of the District of Columbia's mental health care system, through the site visits made at the request of this court on July 7-13, 1982, the Dixon Implementation Monitoring Committee unanimously finds the District defendants substantially out of compliance with the Dixon Consent Order of April 1980. Furthermore, the Committee believes that the deficiencies brought to the court's attention by the plaintiffs in their March 31, 1982 Motion to Enforce the Consent Decree and confirmed by the site-visit team in its August 12 report to the court are the result of serious disincentives to the defendants' compliance within the existing federal/District system. These disincentives are so fundamental, the Committee believes, that the deficiencies can only be corrected and compliance achieved with major new leverage for long-term change.

The Committee therefore recommends as a critical but ultimate goal restructuring the system for serving mentally ill District of Columbia citizens under a single administrative authority. But the Committee also believes that immediate steps must be taken to prevent further harm to the plaintiffs in the short run. Accordingly, it recommends here the appointment of an individual with oversight responsibilities for the District defendants' efforts to achieve compliance with the Dixon Consent Order and Plan and to begin immediately to correct the specific deficiencies in the District's mental health care system identified by the site-visit team.

The following report outlines major areas of noncompliance by the District defendants and analyzes the factors which militate against change. The report then examines the types of concrete management reforms that must be made in order to provide the services required by the Consent Order and Plan.

It is obvious that new incentives are needed to produce these reforms, given that the District of Columbia Department of Human

Services (DHS) has already spent half a decade planning for implementation of this Court's 1975 order without achieving compliance. The Dixon Final Implementation Plan states that as of February 1980, "DHS and SEH have, for the past 2-1/2 years, engaged in joint planning activities concerning the funding and delivery of mental health services to District residents using a coordinated systems approach." (Plan, p. 5.) Since signing the Consent Order in April 1980, the District defendants have spent another 29 months in ineffective planning and implementation.

The District defendants have thus had more than two and a half years to meet their "responsibility to provide patients discharged from SEH with community-based services, including outpatient psychiatric treatment and rehabilitative care and a full range of life support services necessary to assure that individual needs are met, with the goal of maximizing the quality of life and preventing re-hospitalization."^{1/} Yet in virtually every regard they have failed to fulfill that responsibility. Sadly, even if given more time, we believe, the District will not be able to achieve compliance without the new incentives represented by the Committee's recommendations.

II. AREAS OF NONCOMPLIANCE BY DISTRICT DEFENDANTS

The information provided in the August 12, 1982 report of the site-visit team on the status of the District's community mental health centers (CMHCs) conclusively demonstrates that the District of Columbia defendants remain substantially out of compliance with the Consent Decree of April 1980 in the following respects:

1. The District defendants have failed to develop services to meet the needs of approximately 1,300 clients on the SEH rolls who

^{1/} Plan, p. 7. Further, according to the Plan, "DHS's responsibility to provide community support services, as defined in this Plan, extends to all patients as individual needs dictate; its responsibility to provide outpatient psychiatric and rehabilitative care services extends to those patients presently on the rolls of Area A, B & C Community Mental Centers (CMHC) and will expand to include provision of these services to patients discharged from the rolls of Saint Elizabeths Hospital to District-operated mental health centers, as each center's services are expanded according to this Plan." (Plan, p. 7.)

were scheduled to be transferred to the responsibility of the District's CMHCs by October 1, 1982. (Plan, pp. 8-9, 117)

2. The District defendants have failed to devise with the hospital policies and procedures to ensure continuity of care for clients who are in crisis or who are hospitalized and who require the assistance of their community-based primary clinician and/or case manager in order to return them to the community as quickly and as successfully as possible. (Plan, p. 61-62; program standards on crisis intervention, case management and evaluation and assessment)

3. The District defendants have failed to provide adequate crisis resolution, patient-advocacy^{2/} and case-management services as mandated by the Plan and program standards. (Plan, pp. 2, 102-103, 117-120, 134-139, 141, 144; program standards on crisis resolution, case management and evaluation and assessment)

4. The District defendants have failed to provide adequate individual evaluation and assessment, treatment planning and follow-through services as required by the Plan and program standards. (Plan, pp. 3, 39-40, 118; program standards on evaluation and assessment, service records and treatment planning)

5. The District defendants have failed to employ sufficient professional and other staff at their CMHCs to meet the requirements of the Plan and program standards. (Plan, pp. 137-138; program standards for each mental health service)

6. The District defendants have failed to develop job descriptions for CMHC staff, documenting areas of work responsibilities and levels of administrative authority assigned, as required by the Plan and program standards. (Program standards, Section I, H-3, position descriptions)

7. The District defendants have failed to provide required reorientation and training to staff who are providing new or different types of services to Dixon clients. (Program standards, Section I, H-4, staff development, training & performance)

^{2/} The District defendants submitted to plaintiffs' counsel on September 13, 1982, a proposal for a patient advocacy system. That proposal is being reviewed by the Dixon Committee staff but has not yet been discussed with the District defendants.

For each of the areas of noncompliance listed above, a series of concrete steps must be taken in order to provide a system of care at the District's CMHCs which meets the needs of Dixon class members. These steps are not hard to identify or difficult to execute. Why, then, have they not been taken?

III. DISINCENTIVES TO THE DEFENDANTS' COMPLIANCE WITH THE DIXON CONSENT ORDER AND PLAN

The Committee believes that the District of Columbia's Mental Health Services Administration (MHSA) has not taken the steps necessary to comply with the Dixon Order and Plan because it is not motivated to make needed changes. As long as it remains less expensive and more expedient for the CMHCs to hospitalize or to terminate clients who are difficult to treat, the Centers' staff will not begin to take the affirmative steps necessary to avert hospitalization or to maximize the quality of life of these clients, as the Plan requires (Plan, p. 7), or even to prevent their further deterioration.

The Committee is now convinced that no matter how many times the District defendants are ordered to achieve any or all of the specific Dixon Plan objectives, they will fail to do so as long as the controlling incentives within the hospital/community system -- money, convenience and job security -- militate for the status quo rather than for compliance with the Dixon mandate.

Specifically, the District pays St. Elizabeths Hospital a flat sum yearly to hospitalize patients from the District; the amount does not vary with the number of people hospitalized. When the District must choose between trying to maintain a difficult patient in the community or hospitalizing him, the financial incentives are for hospitalization; it costs no more and reduces the workload of a burdened system. Furthermore, when the client is released, no money for his care accompanies him out of the hospital to pay for the services he needs in the community. This is why more people cannot now be served in accordance with the Dixon Plan without dangerously diluting the already inadequate capacity of the community mental

health system. (For further discussion of the implications of this financial structure, see the paper by Leonard Stein, "The Dollar Follows the Patient: Wisconsin's System for Funding Mental Health Services," attached to the site-visit report.)

The incentives applicable to St. Elizabeths Hospital also militate against compliance with the Dixon Plan. Even though the hospital operates on a fixed annual budget, it has little to gain and potentially much to lose by transferring large numbers of inpatients to the community. A diminishing hospital census could lead to budget cuts and staff reductions. (At the moment, however, given the deplorable state of the District's services, the hospital is not under great pressure to transfer patients.)

IV. RECOMMENDATIONS

A. Systemic Reorganization

The Committee believes the total resources in terms of money and staff now present in the entire system (District of Columbia Mental Health Services Administration and St. Elizabeths Hospital) are sufficient to develop a truly excellent comprehensive mental health care system, in which the community would be the primary locus of care and the hospital would play an important role as one element. Ultimately, creation of such a system will require reorganization of the existing elements, placing St. Elizabeths Hospital and the District of Columbia's mental health services under the same administrative structure. Only with a central administration, a single budget and enlightened leadership can the resources of the present combined systems be managed in such a way as to motivate compliance with the Dixon mandate in the long run. Accordingly, although this Committee is expert in the administration and delivery of mental health services, and not in what courts will or will not order, it makes as its primary recommendation the creation of a unified system.

The recommendation is not new. It has been considered by the D.C. government, the Department of Health, Education and Welfare

(now Health and Human Services) and the House Committee on the District of Columbia. It was made in 1964 by the Advisory Group on the Future of St. Elizabeths Hospital; in 1967 by the National Institute of Mental Health; in 1970 by the Advisory Committee on the Transfer of St. Elizabeths Hospital to the District of Columbia Government (Rome Committee); in 1973 by the Presidential Reorganization Authority; again in 1973 by Proposed Transfer Legislation; and in 1977 by H.R. 3355 -- A Bill to Establish a Government Corporation to Operate St. Elizabeths Hospital; again in 1977 by the SEH Initiative; and in 1980 by a proposal for the Establishment of a Government Corporation to Manage the Delivery of Mental Health Services.^{3/} Most commonly, it includes a proposal to establish a semiautonomous public corporation.

The establishment of a single authority over a unified, comprehensive, coordinated mental health system must not be undertaken without careful planning and safeguards to protect the interests of Dixon class members. Yet the Committee believes that such an undertaking would create the strong internal incentives needed for long-term compliance with the Dixon Plan and strongly recommends that every effort be made to implement this remedy as quickly as possible.

B. Appointment of an Effective Overseer

Until the long-term goal of bringing all mental health services under a unified, comprehensive, coordinated system is reached, the Committee recommends that as an interim step the court appoint an individual from outside the hospital and District systems who can exert leverage to overcome many of the barriers to change inherent in the District's existing system and who can correct immediately many of the deficiencies found by the site-visit team.

^{3/} For the past two years, the Dixon Committee has tried to obtain copies of relevant documents concerning the federal and District governments' plans to unify the SEH-D.C. mental health system, but all requests have been denied. Recently, the Committee was able to obtain through informal channels a copy of a briefing memorandum of November 7, 1980 (Attachment A). The Committee does not necessarily endorse or dispute any of the recommendations contained in this report; it is provided here merely to inform the court about the types of issues under consideration by the two defendants.

Such an overseer must be given broad-based authority over the District defendants' budget requests for staffing of and procedures and policies governing community-based services needed by the plaintiff class. Furthermore, the overseer must be empowered to negotiate directly with SEH concerning client-care issues that require the cooperation and coordination of hospital staff to implement the Dixon decree.

The Committee recommends appointment of a mental health professional who has demonstrated strong clinical and management skills, particularly in serving severely disabled adult clients in a community-based mental health system that provides the kinds of services required by the Dixon Plan.

The Dixon Committee believes that a court-appointed overseer of the District's mental health system with the above qualifications and authority could correct many of the existing deficiencies and lay the groundwork for a unified system of mental health care in the District of Columbia. Without external management of this sort, however, the Committee is convinced that the District defendants will never comply with the consent order and the needs of the plaintiff class will never be met.

V. TECHNIQUES FOR COMPLIANCE

If the system mandated by Dixon is to work, line staff at the CMHCs must fully understand and adhere to all directives. A primary clinical responsibility of an overseer must be to ensure that staff know how to actually develop each service in order to meet the Dixon requirements and provide clinically appropriate services to members of the Dixon class.

A. Two Examples of Step-by-Step Improvement

To illustrate this point, we itemize below the steps that must be taken to bring two services, crisis intervention and case management, into compliance with the Dixon Plan. Similar action-oriented tasks would need to be identified and achieved in order to remedy

each of the other service deficiencies reported by the site-visit team.

Example 1. Crisis Resolution Unit

Based upon the evidence in the site-visit report about the Crisis Resolution Unit (CRU), the Dixon Committee concludes that the CRU is being underutilized because it does not perform a useful clinical function. It does not make adequate assessments of the client's mental health, residential and supportive-living needs at the time of crisis. It does not develop and implement a short-term treatment plan responsive to those needs. It does not provide for meeting those needs until a long-term treatment plan can be developed. It does not stabilize the client. It does not prevent deterioration. It does not avert hospitalization. It does not resolve the crisis in the least restrictive alternative. In short, it simply does not perform the functions that might reasonably be expected of a crisis resolution unit.

For the CRU to be useful, it must change the way it operates. The primary locus of crisis resolution must be with the CRU staff. Specifically, the following management objectives must be achieved:

*** Outreach. CRU staff must provide outreach seven days a week, 24 hours a day. Outreach staff must understand that their goal is to evaluate the client's situation and try to resolve the crisis -- first, in the place where it occurs; second, if necessary, in a temporary residential crisis facility; and third, only as a last resort, in a hospital. In every instance, the staff must understand that the short- and long-term goal is to stabilize the client and to prevent his further deterioration.

The outreach response of CRU staff must be timely (that is, within hours, not days or weeks).

*** Continuity. Although other treatment personnel (e.g., CMHC case managers or primary clinicians) may be involved, CRU staff must follow a client who is in crisis until he has been

linked with another service and can be maintained by that service. Until the transfer of treatment responsibility is complete, the CRU staff should develop a short-term treatment plan, based upon a needs assessment of the client, and should provide whatever mental health services that client needs, including case management. This means that CRU staff may need to follow a client for several days or several weeks in order to ensure that the crisis is resolved in the least restrictive alternative, that the client is stabilized and that all reasonable steps have been taken to avert hospitalization and to prevent deterioration.

*** Linkage. Once the client has been stabilized, CRU staff must notify the agency to which it refers a client to expect that client. In fact, CRU staff should set up the first appointment for the client, make sure the client knows when and where it is and, if necessary, accompany the client to the first appointment. Finally, CRU staff must request a timely report back whether or not the client was actually seen and what continued treatment expectations the other agency may have for the client. These actions should all be documented.

*** Capability to Transfer Clients. If a client cannot be maintained where the crisis occurred, CRU staff may have to move the client to a temporary residential crisis facility. If such facilities have no beds open, the CRU program manager must document and report the shortage to the overseer, who must take steps to expand the contract capacity to secure such beds.

A vehicle is needed to transport clients who are in crisis and whose physical health is in jeopardy. The CRU must have a suitable vehicle available 24 hours a day, seven days a week.

*** Accountability. The CRU staff must maintain records documenting specific steps taken to resolve each crisis in a timely, effective manner in the least restrictive alternative. These records must be reviewed regularly by the CRU program

manager and should serve as a basis for ongoing staff training and program evaluation.

The CRU staff must also track each client and the program manager must report to the overseer every three months on the outcome of crisis intervention. Specifically, staff should report how many clients were hospitalized, how many were placed in a temporary residential crisis facility, how many averted hospitalization by being referred to another agency and how many were not linked with another agency.

In order to comply with these basic obligations, the total number of CRU staff must, at a minimum, be maintained at the present level. However, the composition -- particularly of supervisory personnel -- and functioning of CRU staff must change as follows:^{4/}

(a) A program manager must be hired who is a mental health professional (psychiatrist, R.N., M.S.W., psychologist) with direct experience in the operation of an effective CRU. The program manager must have clinical expertise in effective crisis resolution and must provide on-line supervision of all CRU staff.

(b) Each shift must have a supervisor who is a professional (physician, M.S.W., R.N., psychologist) trained in community-based crisis resolution. This person must be willing and able to do outreach and to supervise all on-line crisis resolution services during the shift.

(c) In addition to direct training by supervisors, on-line staff may receive additional in-service training, such as observation of a successful CRU in another jurisdiction.

(d) To ensure that each member of the CRU understands his own responsibilities, job descriptions must be developed, defining functional areas of work responsibility and levels of assigned authority.

^{4/} These are the minimal staffing requirements; other changes and additions may be needed.

(e) Staffing arrangements must permit shift-change meetings for discussion of all crisis contacts. At such meetings, staff must review how each crisis was handled, what else might have been done and what should be done by the next shift. Notes must be kept of each shift-change meeting.

Example 2. Case Management

The site-visit team found that the District defendants have virtually ignored the requirements of the Dixon Plan and program standards for effective case management. No identifiable interdisciplinary team exists to provide individual needs assessment, treatment planning, assignment of a case manager or follow-through and evaluation of client progress on a case-by-case basis; present high client-staff ratios make for unmanageable caseloads and a disjointed treatment approach. The actual role of the case manager is not even understood; the case-manager role is seen as subservient to the clinician's, with a lower priority, and CMHC staff are unaware of the crucial interplay between the clinician and case-manager functions. Current staff do not assume the responsibility for and do not understand the methods necessary for making effective referral and follow-up services for their clients. In direct violation of the Dixon program standards, case-management responsibilities are terminated when a client is rehospitalized. There is inadequate core professional staff to provide the hands-on training vital to case management. Record-keeping is inadequate and sometimes nonexistent. As a result, needs assessments, treatment plans and case-manager assignment are not available for comprehensive and consistent case management. Finally, the federally funded Community Support Project (CSP) which is part of the Dixon Plan is now being terminated, denying crucial case-management services to the chronically mentally disabled.

The Dixon Committee believes that an effective system of case management, as defined by the Dixon Plan and program standards, absolutely must be in place prior to the transfer of additional clients from St. Elizabeths Hospital. The absence of such a system

can only exacerbate the already-ineffectual service delivery system. Accordingly, the Dixon Committee believes that the following management steps must be taken. If they are, the result will be an effective case-management system.

(a) An individualized treatment plan (ITP), as defined in the Dixon program standards, must be recorded in each client's case record and re-evaluated at least every six months. The initial ITP and any re-evaluation must be the cooperative judgment of an interdisciplinary treatment team, whose names must be entered in the case record.

A member of the interdisciplinary treatment team must be appointed as the client's case manager to aggressively carry out the items in the ITP; progress notes as defined by the Dixon program standards, recorded regularly and signed by the case manager, will show how the case manager is carrying out his responsibilities.

(b) Additional staff must be brought on (hired or assigned) to comply with the mandated maximum staff/client ratio for case management of 1 to 40, and each case manager must be part of an identifiable interdisciplinary treatment team.

(c) The additional staff brought on must include enough mental health professionals to comply with the requirement that treatment be coordinated by interdisciplinary treatment teams with adequate supervision of mental health technicians.

(d) New job descriptions must be written for current and new staff who will perform case-management functions. The job descriptions must go into effect forthwith and must reflect the responsibilities defined for case managers in the Dixon program standards.

(e) A program manager for case management should be hired at each CMHC, to be responsible for the training and ongoing supervision of all staff providing case management at the center and for recording of case-management services. Topics of training should include the service needs of chronically men-

tally ill people in the community, the responsibilities of the interdisciplinary team and case managers and recordkeeping requirements and methodology. This person must demonstrate an understanding of and commitment to the case-management responsibilities outlined in the Plan and program standards.

B. The Responsibilities and Authority of an Overseer

To assure that these tasks can be carried out, the Committee believes that the overseer must be given the responsibility and full authority to secure and manage all resources needed by the District defendants to implement the Dixon mandate and to coordinate activities with the hospital in order to correct immediately each deficiency reported by the site-visit team, reporting to the court on progress at three-month intervals.

The overseer's first tasks must be to develop clear, short-term management objectives to correct each of the deficiencies reported by the site-visit team, to set priorities and to establish timelines for the achievement of each objective. These should all be in writing.

Next, the overseer would have to determine the resources needed to accomplish each task and whether or not those resources are available in the District's mental health system; he or she must be empowered to secure -- if necessary, from outside the system -- sufficient well-trained and qualified staff to carry out the objectives. Finally, the overseer must be empowered to implement program and organizational policies and procedures which encourage rather than impede achievement of the goals of Dixon.

The Committee recommends that the overseer be given, at a minimum, the authority and responsibility to achieve the following specific tasks:

1. Budgetary and Fiscal Oversight

(a) Assure participation by CMHC program managers in budget requests.

(b) When new budget requests are made by MHSA, the over-

seer must have adequate time for review and input before the final budget is submitted to the authorizing body. Furthermore, the overseer must be given an opportunity to present an alternative if he finds the budget developed by the defendants inadequate.

2. Staffing

(a) If, in the overseer's judgment, sufficient qualified staff cannot be found among existing MHSA staff to provide community-based services, hire qualified staff.

(b) Secure (by redeploying or hiring) program managers who, in the overseer's opinion, are qualified to manage a particular clinical service and who will report directly to the overseer.

(c) Determine the number and professional composition of staff positions needed to provide each service and to comply with the Dixon program standards, set qualifications for each position, and assure that program managers hire new staff and/or redeploy existing staff to achieve necessary staffing levels.

(d) Assure redeployment of staff who are now in program-manager positions, but who the overseer finds unqualified to manage a particular clinical service. (The site-visit team reported serious staff shortages at the CMHCs in all professional categories. Accordingly, employees would be unlikely to lose jobs; rather they would move to jobs where they are needed and for which they are qualified.)

(e) Assure that job descriptions for each community-based staff position are written, reflecting current functional job responsibilities, maximum caseloads and administrative authority assigned, and assure provision of the type and amount of training and supervision needed by staff to carry out their responsibilities according to the job description.

3. Programmatic & Organizational Policies & Procedures

(a) Assure that the information necessary to provide meaningful program evaluation of various aspects of the community-based service system is collected, reviewed and acted upon in a timely manner in order to change parts of the system that are not working and to strengthen and preserve those that are.

(b) Assure that contracts with existing service providers are sufficient and appropriate to implement the Dixon decree, and expand, decrease or terminate contracts, as the overseer finds appropriate.

(c) Assure that current residential facilities and other support services in the community are sufficient and appropriate to meet the needs of Dixon class members, and expand them if necessary.

(d) Assure that the hours of operation of clinical services at the CMHCs give Dixon clients reasonable access to such services (e.g., evening hours at the Lithium Clinic for clients who work during the day).

(e) Assure development of training affiliations with local universities and other professional and service entities and associations, including the police.

(f) Establish policies and procedures which encourage rather than impede compliance with the objectives of Dixon. The most important of these govern continuity of client care, admissions and discharges from the hospital, and clients' terminations from CMHC rolls.

For example, the overseer must:

-- Assure the development and implementation of a system for St. Elizabeths Hospital to notify immediately the appropriate CMHC/CRU staff if a CMHC client presents himself at the hospital for admission, so that the community-based staff may work quickly to try to avert the

admission and stabilize the client in another, less restrictive setting.

-- Rescind current CMHC policies which require a client's termination from the CMHC rolls when he is hospitalized, and implement new policies to retain such a client on the rolls and allow case managers to carry out their responsibilities to a hospitalized client, as required in the program standards

-- Reassess current policies and, if necessary, develop new policies concerning whether clients can be admitted to SEH without first being evaluated by the CRU.

-- Reassess current policies and, if necessary, develop new policies concerning whether clients can be discharged from SEH without the involvement of a CMHC case manager to develop a community treatment plan and ensure continuity of care.

-- Require the hospital to send each CMHC a daily printout of all clients in its catchment area who were hospitalized, to allow for continuity of care and encourage the early return of the client to the community.

-- Require that each person hospitalized be assigned a case manager at the appropriate CMHC within 48 hours of admission to SEH.

(g) Once all parties agree that the major deficiencies enumerated in the site-visit report have been corrected and that the District system has sufficient resources to meet the needs of Dixon class members, determine the number of SEH outpatients and inpatients who should be transferred to each CMHC's responsibility within a specified period of time, and ensure that the transfers occur.

VI. CONCLUSION

It is the unanimous opinion of the Dixon Committee that two and a half years after agreeing to carry out specific planning and

phased-implementation activities, the District of Columbia government is out of compliance with the Dixon Consent Order concerning the delivery of essential mental health services in virtually every regard. The areas of noncompliance are so fundamental, so numerous and so pervasive that the Committee earnestly believes that without the appointment of a powerful overseer to manage their efforts, the District defendants are incapable of achieving compliance on their own, no matter how much more time they are given. Moreover, to sustain short-term compliance, the Committee believes that mental health care for District of Columbia citizens must ultimately be provided by a unified system.

When the District of Columbia defendants signed the Consent Order in April 1980 they reaffirmed the commitments they made in the Final Implementation Plan. The principal commitment was in the defendants' acknowledgment that "the provision of adequate community mental health and support services is the key component of this Plan. Absent these services, deinstitutionalization of patients is an inappropriate goal; with them, deinstitutionalization can result in increased independence and a better quality of life." (Plan, p. 116.)

Through their failure to provide needed services, the District defendants have deprived Dixon class members of the opportunity for increased independence and a better quality of life. Moreover, they have placed many class members in the untenable position of either having to leave the community and return to the institution, where some of the mental health services they need are available, or having to stay in the community without adequate mental health care.

Citizens of the District of Columbia have been waiting for the community mental health services to which they are legally entitled. They have waited since December 1975, when this court ordered the defendants to work together to meet the needs of the plaintiff class in the least restrictive setting appropriate to their individual needs. They have waited since April 1980, when the defendants

signed the Consent Order agreeing to implement the Final Implementation Plan. They are still waiting.

The members of the Dixon class should not be asked to wait any longer. They cannot afford to pay -- with their freedom and with their dignity -- for the District defendants' chronic inability to provide adequate mental health services.

The Dixon Implementation Monitoring Committee respectfully urges the Court to appoint an overseer to manage the District's efforts to implement the Dixon decree so that compliance can be achieved in a reasonable period of time and a foundation can be created for the ultimate unification of the mental health system in the District of Columbia.

Submitted by: *

Joseph J. Bevilacqua, Ph.D.
Robert E. Collins
Ronald Diamond, M.D.
Gail Marker, M.S.W.
Charles E. Morgan, Esq.
Marlene Ross, M.A.
Dorothy Sharpe
Leonard I. Stein, M.D.

* Dr. Diamond is not a member of the Dixon Committee, but agreed, as a member of the expert site-visit team, to participate in the formulation of proposed remedies. Drs. Fougy, Mills and Collins and Ms. Ross were members of the site-visit team and joined as signators of the August 12, 1982 Report to the Court. However, Drs. Fougy and Mills chose not to participate in developing the recommendations contained in this document. Dr. Collins is on sabbatical and unavailable at present. Ms. Ross has contributed to this report but was unavailable to review it in final form.

LETTER FROM NORMAN S. ROSENBERG, DIRECTOR, MENTAL HEALTH LAW PROJECT

August 12, 1982

The Honorable Aubrey Robinson
United States District Court for
the District of Columbia
United States Courthouse
Washington, D.C. 20001

Dear Judge Robinson:

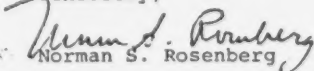
Pursuant to the Court's order, enclosed is a report on the site visits to the District of Columbia's community mental health centers. The site-visit teams received full cooperation of MHSA and CMHC staff and had an opportunity to evaluate fully the centers' activities which are mandated by the Dixon Consent Order and Plan.

As you will see from the report, the team has identified serious deficiencies in the design of the system and in the delivery of services to Dixon class members. These deficiencies are: (1) a scarcity of resources in the community mental health centers which in effect encourages hospitalization of clients; (2) a community-services system that is not designed to meet the needs of the severely disabled people who comprise the majority of Dixon class members; and (3) fragmentation of services at both the individual and systemic levels -- a system so disjointed that clients either are hospitalized or disappear from the mental health system, even though they may still need its services.

The site-visit team strongly believes that any remedies proposed must address these systemic deficiencies, and must do so quickly.

Plaintiffs' counsel intends to convene a meeting of the Dixon Committee and the full site-visit team as soon as possible after Labor Day to develop recommendations and propose them to the Court on or about September 30.

Sincerely,


Norman S. Rosenberg

REPORT TO THE COURT: SITE VISITS TO DISTRICT COMMUNITY MENTAL HEALTH CENTERS,
JULY 7-13, 1982

INTRODUCTION

At the request of the court, representatives of the Dixon Implementation Monitoring Committee, St. Elizabeths Hospital and the Washington Psychiatric Society (hereinafter the "site-visit team" or "the teams") conducted site visits of the District of Columbia's community mental health centers (CMHCs) from July 7 to 13 for the purpose of determining the centers' capacity to provide services to

the plaintiff class in Dixon v. Schweiker, "formerly institutionalized mental patients and those who may be institutionalized in the District of Columbia." (Plan, page 1) The site-visit team was particularly interested in assessing the centers' ability to serve clients who are to be transferred from St. Elizabeths Hospital to the District's responsibility under the April 1980 Consent Order and Plan.

Throughout the Dixon litigation, the plaintiff class has included people with a range of disabilities, among them a great many chronically and severely disabled persons. However, the site-visit team found that the mental health system operated by the District of Columbia is only capable of serving people who need relatively minimal services in order to live in the community. The system does not adequately serve people whose severe mental health and coping problems require intensive outreach and follow-along services to prevent hospitalization or other serious problems. It is clearly not prepared to serve such clients who are scheduled to be transferred from St. Elizabeths Hospital to the District's responsibility under the Dixon Consent Order.

The specific problems observed by the team members highlight three critical deficiencies which render the District's community mental health system unable to meet its obligations to these clients. These deficiencies are: (1) a scarcity of resources in the community-services system, which, in effect, encourages hospitalization of clients; (2) a community-service system that is not designed to meet the needs of the chronic, severely disabled people who comprise the majority of Dixon class members; and (3) fragmentation of services at both individual and systemic levels -- a system so disjointed that many clients cannot cope effectively in the community and as a result disappear from the mental health system, even though they may need its services, or are hospitalized.

The report which follows describes, in terms of the Dixon Consent Order and Plan, the problems that led the site-visit team to identify these systemic deficiencies, and provides supporting data for the conclusions reached by team members.

SITE-VISIT PROCEDURES

Site visitors to the centers divided into three teams. Team I reviewed the South Center and the patient advocacy service; it was composed of Marlene Ross, M.A., Dixon Committee representative; Michael Mills, Ph.D., St. Elizabeths Hospital representative; and Joseph Bevilacqua, Ph.D., Dixon Committee representative. Team I conducted its visit to South Center on July 7, 8 and 9. Its primary focus was on the Adult Outpatient and Day Treatment Departments, but the team also briefly visited the satellite geriatric program and the new Lithium Clinic.

Team II reviewed the North Center; it was composed of Ronald Diamond, M.D., Dixon Committee representative; Ghislaine Fougy, M.D., St. Elizabeths Hospital representative; and James Collins, M.D., Washington Psychiatric Society representative. Leonard Stein, M.D., Dixon Committee representative, also reviewed some of the North Center's activities. Team II conducted its visit to North Center on July 9, 12 and 13. Its primary focus was on the Adult Outpatient and Day Treatment Departments; the team also reviewed the geriatric program. No records were reviewed at the P Street Clinic.

Leonard Stein, M.D., and Gail Marker, M.S.W., staff coordinator of the Dixon Committee, comprised Team III. Team III reviewed the Crisis Resolution Unit on July 11 and 12.

Gail Marker also provided assistance to Teams I and II. During the week of the site visit, members of the three teams met as a group to ensure consistency of the process.

The teams did not visit or review any of the services for youth, because time was short and the Dixon class members are primarily adults. However, MHSA and the centers' staff thought such a review would be helpful; it could be scheduled at another time.

Each team received a thorough orientation from the Director of the Mental Health Services Administration (MHSA) and other top administration and CMHC staff. Members were also given notebooks with detailed information about the centers' operation.

Both CMHC and MHSA staff were extremely open and helpful to the site-visit teams.

Following the site visits, team members presented their general findings and concerns to the Director of the Department of Human

Services, the Director of MHSA and the respective center and administration staff.

The following sections of this report reflect the concerns of the full site-visit team. They are based on observations of actual programs, interviews with staff and clients, review of documents provided by MHSA and review of 119 individual client records (54 from the Crisis Resolution Unit, 34 from North Center, 31 from South Center).

PHYSICAL PLANT

At each site, the physical plant appeared to be generally clean and safe. However, some deficiencies were noted. There were no smoke detectors in some patient areas and hallways at South Center. North Center was extremely hot, causing concern about the welfare of elderly clients and those on high doses of psychotropic drugs, who are very susceptible to heat prostration.

Above all, the teams were disturbed by the overall starkness and institutional feeling of the centers. There were few pictures, plants, magazines and other human touches. With the exception of one or two areas, there is little about the centers' environment that engenders a sense of comfort and warmth.

Creating a more homelike environment would cost little. In addition to making the centers more conducive to treatment, it would provide an opportunity for clients to help plan and carry out the revitalization of their own environment.

SERVICES

The site-visit team found serious inadequacies in the delivery of critical services mandated by the Dixon Plan. The problems observed by team members revealed three major systemic deficiencies, described below.

- I. A scarcity of resources in the community mental health centers precludes the delivery of adequate services to severely disabled clients living in the community and encourages their rehospitalization.

The way mental health delivery systems are organized and paid for is a powerful force in shaping the nature and adequacy of the

services delivered. (For a more detailed discussion on this, see Attachment A, "The Dollar Follows the Patient: Wisconsin's System for Funding Mental Health Services," a paper by Leonard I. Stein, M.D., and Leonard J. Ganser, M.D.)

Research shows that the availability of comprehensive community services dramatically reduces the need to use the hospital and produces a superior long-term clinical result (Stein and Test, 1980).

A. FINANCIAL RESOURCES

A comprehensive system of care -- one that is truly responsive to those in greatest need -- cannot be developed without sufficient resources for services in the community.

The site-visit team believes that in order to meet the Dixon mandate of shifting the primary locus of care for the plaintiff class from "a large inpatient psychiatric institution to a comprehensive community-based mental health service delivery system" (Plan, page 2), the community mental health care system must be adequately financed. Yet the District's Mental Health Services Administration and its community mental health centers, required by the Dixon Plan to provide comprehensive services, have a budget of only \$11 million.

St. Elizabeths Hospital has a high number of admissions and readmissions each year. In 1981 there were 5,191 admissions; 68 percent of these (3,510) were "readmissions." Both new admissions and readmissions have gone up, instead of down, since 1980. (Semi-annual Progress Report, October 1981, Enclosure F.) This "revolving door" phenomenon is the result of a scarcity of community services to help stabilize chronically mentally ill clients. Once appropriate community services are available, many of the clients who now revolve in and out of the hospital (or who simply disappear from the system) could be stabilized and cared for in the community. But at this time, the District has neither financial incentive nor resources to meet these clients' needs as mandated by the Dixon Plan.

B. STAFF RESOURCES

The lack of resources for services in the community is especially dramatic when stated in terms of numbers, professional training and responsibilities of CMHC staff.

The site-visit teams found the staff at both centers conscientious, hard-working and dedicated. They appear to be doing a relatively good job of serving clients who are stable and who need minimal services, such as medication once or twice a month and checking in once a month to see how things are going. Staff seem to know these clients well, and when one misses a medication appointment, will try to get in touch with him immediately.

However, with the exception of the Crisis Resolution Unit, discussed in section II below, the CMHCs are not staffed to provide much more --certainly not to comply with the requirements of the Dixon Plan. Insufficient training and excessive caseloads make it impossible for the staff to follow up when clients become unstable or go into crisis. Further, the absence of assertive case management and the lack of effective outreach prevent the centers from adequately serving many clients who require different and more intensive kinds of services than the centers are now delivering. And a deficit in full-time professional staff precludes proper supervision of nonprofessional personnel and renders impossible the interdisciplinary approach to individual needs assessments and treatment planning required by the Dixon program standards for Patient Evaluation/Assessment.^{1/}

(1) Ratios of professional staff to clients

As of June 30, 1982, a total of 976 patients were on the Adult Day Treatment and Outpatient Department (OPD) rolls of South Center.^{2/} They are served by the full-time equivalent of the following direct-care professional staff:^{3/}

^{1/} The Dixon program standards are not paginated; therefore, they are cited here by reference to the relevant sections.

^{2/} This figure was provided to the site-visit team over the phone by MHSA on July 30.

^{3/} From staffing charts provided by the MHSA on July 27, 1982, based on a 40-hour week. St. Elizabeths Hospital staff assigned to the centers are not included, nor are staff assigned to the Crisis Resolution and Detoxification Units or purely administrative staff.

1.25 psychiatrists
 3 medical doctors
 4 registered nurses
 2 professional social workers
 1.5 psychologists

The above professional staff equate to the following staff-client ratios:

psychiatrists: 1:781
 medical doctors: 1:325
 registered nurses: 1:244
 professional social workers: 1:488
 psychologists: 1:651

At North Center, the staffing levels are only slightly better. A total of 792 clients on the Adult Day Treatment and OPD rolls^{4/} are served by the full-time equivalent of the following direct-care professional staff:^{5/}

1.9 psychiatrists
 1.8 medical doctors
 7 registered nurses
 5.3 professional social workers
 2 psychologists
 1 masters in counseling

The above professional staff equate to the following staff-client ratios:

psychiatrists: 1:417
 medical doctors: 1:440
 registered nurses: 1:113
 professional social workers: 1:149
 psychologists: 1:390
 masters in counseling: 1:792

These numbers mean that if, for example, all clients at South Center needed to see a psychiatrist monthly, each could be seen for at most 12 minutes a month. Of course, not every client needs to

^{4/} See footnote 2.

^{5/} See footnote 3.

see a psychiatrist once a month, but many do, and a number will need more frequent psychiatric contact. The staffing shortages make this extremely difficult, if not impossible.

For comparison, the Dixon program standards (see Section C2, Standards for Each Mental Health Service) require 16.8 minutes per monthly contact for a psychiatrist to provide assessment and prescription of drug therapy and 33.6 minutes per monthly contact for a psychiatrist to perform individual evaluations and assessments for clients who need it. If the psychiatrist were also providing individual, group or family therapy, he would be required to spend an average of another 50 minutes every week and a half for each client to whom he was providing this service. In addition to these job responsibilities, according to accepted professional practice the psychiatrist should provide case consultation, document records and supervise staff.

Professional staff in other disciplines are similarly constrained by virtue of their scarcity. Although paraprofessionals have a vital place in the service-delivery system, the Dixon standards assume enough "core mental health professionals" (e.g., psychiatrists, psychologists, masters in social work, registered nurses) to deliver direct services and to supervise nonprofessional staff.

Furthermore, the centers' current staffing arrangements interfere with the continuity of care envisioned by Dixon. Many of the professionals only work part time. For example, although 15 individual psychiatrists are employed by the centers to provide adult services, not one works full time; most work for the centers fewer than six hours weekly. The site-visit team doubts that proper continuity of care can be delivered by a system whose few professional staff are available so infrequently.

(2) Excessive caseloads

An analysis of caseloads reveals equally troubling results. The Dixon standards require 40 clients as a maximum caseload for clinicians/case managers (see Plan, p. 138). Almost one-quarter (21) of the 88 direct-care staff employed in Adult Services at North and South Centers (excluding staff assigned by the hospital) have case-

loads that violate Dixon standards. Some carry caseloads as high as 70 to 150 clients. And, although MHSA staff could neither confirm nor deny it, it appeared to the team that these 21 professionals are the primary clinician/case managers for their caseloads.

(3) Unclear responsibilities

The program standards require position descriptions for each staff member, documenting areas of work responsibility and levels of administrative authority assigned. (See Program Standards, Section I, H-3, Position Descriptions.) The teams were given copies of general job descriptions, but were told that these descriptions, for the most part, no longer applied because of the current reorganization of services. The teams then asked for a functional description of the job responsibilities of each staff member at that specific time. The centers were unable to provide these descriptions.

To cover such transitional periods, the standards require that "[e]mployees who are changing job descriptions or who are involved in delivering a new or different type of service shall also be provided with suitable reorientation and retraining, as appropriate. In addition, staff shall be provided with appropriate ongoing in-service training to help maximize their skills and interest." (See Program Standards, Section I, H-4, Staff Development, Training and Performance.) With the exception of a brief seminar on case management, the site-visit team found no evidence of any such training.

For example, the new Lithium Clinic, housed at South Center, is run by a general medical officer who reported to the team that she had no experience with lithium and was "just learning."

C. THE SYSTEM'S INABILITY TO SERVE ADDITIONAL CHRONICALLY MENTALLY ILL CLIENTS

The site-visit teams found, as itemized above, that the District's CMHCs currently lack the staff capacity to provide adequate services to severely disabled chronically mentally ill persons -- the clients for whom the Dixon Plan was primarily intended. It is therefore inconceivable that the CMHCs could absorb any more such clients, particularly those who will be transferred from St. Elizabeths Hospital, without additional resources.

During the site visit, the teams found that the Day Treatment

Units (for adults and geriatrics), which typically serve the more disabled clients, are stretched to the limit and cannot absorb more clients. The Spring Road Day Treatment Unit has four full-time staff, including a registered nurse (who is also the team leader), a nursing assistant and two mental health technicians. Two part-time psychiatrists handle medical backup for the unit. The unit had approximately twice this staff and twice as much psychiatric time until a year ago, when cutbacks eliminated approximately half the staff, including the masters-level social worker who was the program manager, and reduced the psychiatric hours available to the unit by half. The Day Treatment Unit at P Street reports a waiting list of two weeks to two months for admission. The Geriatric Unit at Spring Road has lost one staff member and has difficulty providing needed follow-through; it also reports a waiting list.

Another significant resource problem involves medical care, which the District is required by the Dixon Plan to provide. North Center, for example, has a dedicated medical officer whose primary assignment is to offer general medical care at no charge. However, some aspects of the service, such as routine chest X-rays, have been difficult to arrange. Furthermore, it is unlikely that additional clients can be served by the current medical staff. If the medical capacity is not expanded, through more medical personnel at the centers and/or by providing case management services to assist clients in obtaining needed medical services elsewhere, as required in the Dixon Plan (see Plan, p. 145), clients will simply not be able to get the medical services they need.

Clearly, the District's CMHCs cannot meet the treatment needs of the client group the Dixon Plan is designed to serve. However, it is not enough for the District simply to hire more staff. First, MHSA needs to review its service system, to define specific priorities and strategies for delivering services needed by chronic, severely disabled clients, and to set target dates for implementing those strategies. Because the system has already endured one major reorganization, which appears to have been very disruptive and has done little to improve services to Dixon class members, it is especially important to think these strategies through carefully.

Once an overall strategy is devised, staff who are trained and qualified to meet each of the program's requirements can be recruited. This process must also include an examination of the qualifications and deployment of staff who are to be assigned by St. Elizabeths Hospital. (At a meeting at North Center, the site-visit team was informed by center staff that many of the hospital staff volunteering for assignment at the centers have not had any clinical experience for a long time; these individuals may therefore not be especially useful to the centers.)

In sum, while additional numbers of professional staff are urgently needed at the CMHCs, an overall strategy must be designed first if services provided by the new staff are to be geared to the needs of chronic, severely disabled clients.

- II. Community-system personnel have not designed their services to meet the needs of chronic severely disabled clients, as the Dixon Plan requires. Consequently, clients are in jeopardy of repeated instability, crisis and hospitalization.

While aware that the CMHCs have overall staff shortages, the site-visit team found that even when sufficient resources are available, they are not used appropriately to meet the needs of many severely disabled, chronically mentally ill clients. The team attributes this to a basic misconception by CMHC and MHSA personnel about the needs of these clients, who require, to live in the community, different and more intensive services than the centers have been providing.

There is a great difference between providing outpatient psychotherapy for people who can meet their own needs with reasonable stability and providing for the treatment of a large group of chronically mentally ill patients who have demonstrated by repeated hospitalizations and repeated crises that they are unable to cope effectively without intensive, specially designed supportive and therapeutic services. The District's approach to providing three key services -- crisis resolution, case management and patient advocacy -- illustrates the problem.

A. CRISIS RESOLUTION

Dr. Leonard Stein evaluated the District's Crisis Resolution Unit (CRU). His conclusions are based on his reading of the material specifically prepared by MHSA for the site visit; on his being at the CRU on Sunday night, July 11, 1982, and a good part of Monday, July 12, with ample opportunity to talk with the staff and observe the operation; on a careful review of the walk-in log sheet for the period June 15 through June 30; and on his review of 40 consecutive records kept from June 23 through June 30. Gail Marker, M.S.W., assisted Dr. Stein in gathering data about the CRU's telephone response by reviewing nine consecutive records drawn from the telephone log of June 20 through June 26 and five records drawn at random from the May telephone log.

The program standards for Crisis Intervention/Resolution identify three objectives for that service: (1) the immediate reduction of acute emotional distress and its physical and social manifestations; (2) assurance of the safety of the client and of others; and (3) minimal disruption to the client by resolution of the crisis in the least restrictive setting appropriate to the nature of the crisis.

In pursuing these objectives, four functions are required:

- identification of the nature of the crisis and the personal situational circumstances that have contributed as proximate causal factors;
- immediate action to facilitate stabilization either by provision of direct services or referral of the patient/client to another site where direct service is promptly available (referrals should often be accompanied by direct assistance in making contact with the intended provider);
- immediate identification and direct involvement of the treatment staff who have the most knowledge about and familiarity with the patient/client; and
- commitment to assess and attempt to resolve the crisis in the least restrictive setting appropriate to the nature of the crisis, first, by resolving the crisis in the setting where it occurs whenever possible; second, by arranging placement of the patient/client in a temporary residential crisis facility if appropriate; and third, by hospitalizing the client, as the last resort. (Program standards for Crisis Intervention/Resolution.)

The findings described below indicate that the CRU is not a crisis-resolution unit as required by these standards. It is instead primarily a "traffic-directing" unit, or one that does one-

time evaluations and then directs the crisis to another resource.^{6/}

When true crisis resolution is carried out, the person in crisis is generally seen many times to work through the crisis. The CRU rarely sees anyone more than once during the crisis. The CRU records do show that a few people are seen more than once, but a second visit is generally separated by a good deal of time; in fact, it usually represents a different crisis. A comparison with statistics of the Crisis Unit of the Dane County Mental Health Center (Wisconsin) illustrates the point. (Although Dane County is obviously different in many ways from the District, the comparison will show how a true crisis resolution unit operates.) The Dane County Crisis Resolution Unit serves a population of 300,000, or about half that of the District of Columbia. In the past six months its staff dealt face-to-face (not over the telephone) with approximately 1,800 new crises. On the average, unit staff saw someone in crisis five times prior to either ending the case or referring it for treatment after the crisis had been stabilized. Thus, approximately 9,000 face-to-face visits occurred in a six-month period. The District's CRU, serving twice as many people, had fewer than 2,200 face-to-face visits during the past six months, with virtually no multiple visits.

Another useful contrast is in the number of potential hospital admissions that are handled through the crisis unit without the use of hospitalization. The Dane County crisis unit was able to avert hospitalization for 75 percent of the clients presented to it for hospital admission. The closest comparison that can be made for the District's CRU is that of clients brought in by the police (these are generally potential admissions); 83 percent were presented to a hospital for admission and only 17 percent were not.

CRU Staff

The numbers of staff available for each shift are sufficient to carry out the stated three functions of the unit -- crisis telephone

^{6/} In its documents and pleadings, the District has discussed its reliance on the police department for crisis intervention. But police intervention, often necessary to avert violence or other disturbances in the community, is not crisis resolution as contemplated by the program standards.

availability, crisis walk-in availability and outreach capacity --24 hours a day, seven days a week. Although the site-visit team found the CRU staff to be conscientious, most of the mental health technicians, who are the preponderance of CRU staff, are insufficiently trained, oriented and supervised to carry out their stated objective of doing crisis resolution.

Telephone Response

The records kept by the telephone-response staff were quite good. The staff seemed adequately skilled in handling crisis calls that could be managed entirely over the telephone. The system broke down when the crisis presented to the telephone worker required more than a telephone response.

The CRU maintains a log of all phone calls received. Among other things, the log contains notations by CRU staff about the type of referral or follow-up recommended for each phone contact. For the months of April, May and June, the log revealed that the largest number of phone contacts (148) had no referral or follow-up; 96 were referred for follow-up by CRU's staff, 50 were referred to another service (e.g., private hospital or doctor), 29 to North Center, 11 to South Center, 10 to St. Elizabeths Hospital, five to Protective Services and four to the police. None were identified as referrals to Crossing Place -- the temporary crisis residential service under contract to DHS to provide an alternative to hospitalization.

When the telephone worker was unable to persuade the person in crisis to come to the unit, rarely was an outreach made. Of the 96 phone contacts referred for follow-up by CRU staff, the log showed that only 13 were specifically recommended for a home visit. All of these referrals, according to the log, were made between the hours of 9:00 a.m. and 4:30 p.m. No referral for a home visit was made in the evening or early-morning hours. (Five examples of what happened to clients who made a telephone contact with the CRU during the month of June are recounted below, in the outreach section.)

The CRU reported receiving 3,300 calls in the last six months, very few for a crisis resolution unit serving a population of more than 600,000. For comparison, the 24-hour telephone crisis line in Dane County, Wisconsin, serving a population half the size of the

District's, receives approximately 7,200 calls in a six-month period. At this point, the team can only speculate why so few crisis calls are made in the District. However, the two most likely explanations are insufficient public awareness of CRU and the lack of usefulness of the service.

Outreach

Although the CRU has the capacity to do outreach -- sufficient staff and a vehicle at its disposal -- it made only nine outreach visits in the month of June. This means only 5.6 percent of the unit's total face-to-face contacts are outreach contacts. The Dane County crisis unit, by contrast, does outreach on 40 percent of new cases. A possible explanation for this discrepancy is based on the respective goals of the units. The Dane County unit sees itself primarily as a service to resolve crises; when someone is unable or unwilling to come into the center, the staff considers it a clinical necessity to go to where the client is. In the District, it is clear that most CRU staff view outreach as a means to certify a client for hospitalization rather than as a way to try to resolve the crisis and avert hospitalization. For example, if a person in crisis telephones and asks for someone to come out, the telephone worker attempts to determine if the person in crisis is dangerous to himself or others. If not, an outreach is rarely made. However, a follow-up call will be made later to determine the progress of the situation. If the situation continues to deteriorate, periodic telephone contact continues until the person in crisis actually is determined to be dangerous. Then an outreach is made for certification for involuntary hospitalization. A case from the June telephone log illustrates:

Case -- The client's sister (who was visiting from out of town) made an initial phone contact with CRU in April. She reported that her sister was acting confused and hostile, had stopped going to work, refused to answer her phone or door and had stopped her psychiatric treatment. Three days later, CRU staff made a home visit. They determined that the client was not dangerous and "couldn't be put in the hospital at this time against her will." No further interventions or follow-up were offered by CRU, according to the record.

Two months went by. In June the sister again contacted the CRU to report that the client's condition had not improved. She reported that the client was being evicted from her apartment and had not answered her phone

or doorbell for several days. During the next week the sister called the CRU seven times to report on the client's status. Finally, she asked the CRU to make a home visit to her sister, but was told no. Instead, she was told to keep the CRU informed about what happened.

The sister called the GRU the next day to say the client was in very bad shape. The CRU staff told her to call the police or the U.S. Marshal. The sister did so and the marshal brought the client to the CRU, where the staff determined that she was dangerous to herself. She was committed to the hospital.

Ms. Marker reviewed the files of the last four clients who, according to the phone log, were recommended as of June 30, 1982, for a home visit by CRU staff. Brief descriptions of these cases follow, with the response each client received from CRU:

Client 1 -- Client's mother called CRU twice in a three-hour period, reporting that her 36-year-old son was not eating or taking his medication and was very confused and withdrawn. The mother asked that someone see the client. The telephone log reads, "Home visit, if at all possible." However, the client's record does not indicate that a home visit was made or that any other intervention or follow-up was provided by CRU staff. There is no further information about what happened to this client.

Client 2 -- The family called to report that a 74-year-old cousin hadn't eaten for a week, was staying in the basement, was very confused and felt people were trying to kill him. The telephone log reads, "Home visit, if at all possible. Please follow up." The client's record shows that no home visit was made that day. The client's cousin called again the next day to report that she was very worried about the client. The record states that the CRU staff told her "she would be called back about a home visit." She was called that day but was told that CRU could not come to the home to evaluate the client unless the family would pay for an ambulance to transport the client to the hospital. The cousin said the family could bear this expense.

The CRU staff made the home visit that day. They committed the client to St. Elizabeths Hospital. He was transported to the hospital by the ambulance, at the family's expense.

Client 3 -- Client's mother called to report that her 32-year-old daughter, who had a long history of hospitalizations, had recently signed herself out of St. Elizabeths against medical advice and was now very depressed and withdrawn, had stopped eating and caring for her personal needs and was refusing to accept treatment. Two days later the CRU staff made a home visit to see the client's sister (also in crisis), but there are no notes indicating that the client herself was seen or evaluated. The mother called CRU that same day to say the client was doing a little better because she was afraid of being sent back to the hospital. CRU staff advised the mother to take her to North Center for treatment.

There are no further notes in this client's record. However, at the request of the site team, CRU staff called North Center during the site visit and verified that the client had never shown up there. There is no indication that the client received any other intervention or follow-up from the CRU staff.

Client 4 -- The client's mother called, saying she was very worried because her daughter, a 31-year-old woman with a long history of mental illness, had taken her six-year-old child to Baltimore. The mother was fearful for her grandchild's welfare. CRU staff told the client's mother to call Child Protective Services and to call CRU back later that morning. The next note in the record was made two days later, when the mother called to report that Baltimore police had picked up the client and put her in jail because she couldn't pay for a cab she had taken to Baltimore; the child had been placed in an emergency foster home.

Two days later Protective Services called CRU staff to report that the client was still in jail, was very delusional and paranoid and was in need of psychiatric evaluation and treatment. The record contained no further notes about any follow-up or assistance provided by CRU staff to this client.

Whether or not this particular tragedy -- a mother going to jail and her child being sent to an emergency foster home -- could have been averted if more assertive outreach had been provided by the CRU is impossible to say. Three weeks earlier the client's mother had called the CRU, saying the client was "hostile, uncooperative, very confused and acting bizarre." The mother reported that she had tried to get help for her daughter but that the younger woman had refused to go see anyone. The caller was particularly worried about her grandchild. The CRU note reads, "Maybe someone could check this matter out or give a home visit to see what goes on."

The CRU staff had then called Protective Services, who made a home visit. Protective Services reported to CRU that the client was not dangerous, but needed psychiatric help. They did not feel the child's safety was in jeopardy, but said they would keep an eye on the situation.

Two weeks passed before the CRU called the mother to see how the client was doing. The mother informed CRU staff that she had called the police the night before because of the client's uncontrollable behavior. CRU staff told her they would make a home visit in two days.

They made the home visit two days later and, according to the record, "referred client for treatment." (The note does not specify where or when.)

Another two days passed. The mother called to say she was trying to get the client to go to North Center. But, at the request of the site team, the CRU staff verified during the site visit that the client never arrived there.

The next day the client took her child to Baltimore, where she was arrested.

In summary, although the CRU has adequate staff and even though the staff are conscientious, there is a basic misconception about what they should do. Consequently, the CRU is not a crisis-resolution unit; it simply does one-time evaluations and makes referrals. That kind of service is really not capable of averting hospitalization or preventing other serious disruptions in a client's life.

B. CASE MANAGEMENT

The Dixon program standards for Case Management (see "Description of Services") call for case management "to assure the availability of an accountable individual to serve as an advocate, helper and service broker on behalf of the patient/client in linking access to needed services to him/her, to coordinate the various service components, and to assure that the elements of treatment, residential, and supportive services planned for and necessary to optimal community adjustment and continuity of care are provided."

The standards for Case Management specify that case managers' responsibility will include, for example, the following activities:

- Participate in the development of the client's community services plan;

- Monitor whether the client is actually receiving the services called for in the plan, through the client's own reports and by making periodic site visits and by consulting with staff providing each service;

- Aid the client's transition from one service program to another (e.g., by offering to accompany him to a new service until he feels comfortable there);

- Assist the client in claiming public entitlements;

- Act as a resource referral for the client by identifying all mental health, residential and other services to meet a need identified in his Individual Treatment and Community Services Plan and accompany the client, if needed, to help him use these resources;

- Assist the client to find and adjust to suitable housing, and if needed, to negotiate leases, purchase furnishings and household items and find compatible roommates;

- Assist the client to find a suitable job, learn transportation routes, open a bank account and manage money;

- Coordinate with residential and other staff who are providing rehabilitative care to the client;

- Assist the client with crisis resolution by reassessing the client's treatment plan in the event of his hospitalization, by maintaining close contact with a hospitalized client and working closely with hospital staff, and by assisting the client to maintain community ties in order to facilitate his return to the community.

The program standards require that such case management will be rendered to all clients, as prescribed in their Individualized Treatment Plans and by their treatment teams.

Following its interviews with officials and line staff, record evaluations and reviews of documents prepared by MHSA for the site

visit, the team has concluded that case management as described in the Dixon program standards is not available to CMHC clients.

One of the reasons, discussed in section I, above, is the severe staff shortage at the centers. It is inconceivable that someone could be a "clinician/case manager" to 70 or more clients at one time (at four hours per client per month, that would amount to more than nine hours spent every day on case management alone).^{7/} Yet such an assignment of clients to case managers was seen in a number of instances at the two centers.

However, even if more staff are hired to reduce caseloads to a manageable size, there is still a serious misconception about what it means to be a case manager to severely disabled clients. The District's centers use a "clinician/case manager" approach, in which one person is responsible for providing both primary clinical and case-management services for a group of clients. This is a sound model that works well in other centers. However, its success is predicated on a clear understanding that case management is as important as the clinical services and that the two go hand-in-hand.

The research and clinical literature about clients who have limited coping skills, severe disabilities and considerable passivity makes it clear; case management is critical. If the case manager cannot connect the client to or actually provide the services he needs to remain stable in the community, the client is in jeopardy. As the program standards for case management recognize, in practical terms this means the clinician/case manager must often leave the physical confines of the treatment setting to perform helping services, such as teaching the client how to ride the bus to the clinic, going to the Social Security office to help the client get funds to support himself in the community, going with him to help him find a furnished room so he has a decent place to live, even providing assertive outreach outside the center when he is in periods of crisis. However, the site-visit team was advised by MHSA

^{7/} For planning purposes, the standards require four hours per month for a "chronically mentally ill" client. Based upon the information in individual records, the teams could not determine which clients would meet the definition of a "chronic patient," because comprehensive needs assessments and information concerning previous hospitalizations was lacking.

that these types of activities are not considered to be a good use of a clinician's time. (Why is not altogether clear.)

North Center houses the Community Support Project (CSP), a program designed and funded in a number of states by the National Institute of Mental Health (NIMH). This innovative concept is specifically geared to meeting the community-living needs of chronic, severely disabled mentally ill people. Its primary intervention is intensive case management, such as the Dixon program standards require. The District's CSP -- funded by MHSA, an NIMH grant and a St. Elizabeths Hospital contribution of staff resources -- is described in the Dixon Plan as being a "demonstration project" which is to be implemented city-wide in order to provide "services to the chronically mentally disabled ... which is fully responsive to the special needs of this population." (Plan, p. 140)

The site-visit team was informed by North Center staff that the District's CSP is being terminated. Its seven case managers, who are on assignment from St. Elizabeths, will return to the hospital. The other four case managers, who are employed by the District, will be integrated into the existing center services, as will the 300 severely disabled persons now served by the CSP. This transfer will increase the burden on a system already hard-pressed; it may also place these clients in jeopardy, given the current deficit in case-management services now available at the centers.

The site-visit team's concerns about the adequacy of case management were substantiated by the charts provided by MHSA for allocation of staff time to case management and by the team members' review of clinical records selected at random from the centers' adult day treatment and outpatient departments.

According to the staff charts, of 88 part- and full-time center staff,^{8/} only 33 are identified as devoting any time to case-management activity for a total of 1,768 adult clients enrolled at the centers as of June 1982. Of the 33 staff, 11 devote 10 percent or less of their time to providing case-management services, 15 devote

^{8/} See footnote 3.

30 percent or less of their time, six devote 50 percent or less of their time, and only one spends over 50 percent of his time in case management.

The Dixon Plan requires that the District "will provide specialty training in case management skills which will be the prerequisite to the provision of case management services." (Plan, p. 138). Furthermore, the Plan mandates that the District's case managers "will participate in continuing education and consultation to enable each case manager to keep abreast of the growing body of knowledge regarding case management, to share experiences with other case managers as an educational process and to receive current information on the availability of community mental health and support services for their clients." (Id.) With the exception of a brief seminar on case-management services, the site-visit team found that staff given case-management responsibilities appear to have been given little training, reorientation or ongoing supervision to prepare them for working with more severely disabled people than the relatively stable clients with whom they are familiar.

The teams found no evidence of comprehensive case management in the treatment records they reviewed. Individual treatment plans rarely contained recommendations regarding a client's need or lack of need for specific case-management services, such as those identified in the program standards. Similarly, progress notes rarely contained information about the type or duration of specific case-management services provided to the client. Record reviews and observation demonstrated to the teams that the bulk of case-management time at both centers is currently spent in obtaining a brief status report from a client when he comes to the center for medication review and in making a general and brief report to the physician on "how client is doing." While this is appropriate for some clients, others need much more. Outreach capability was particularly deficient. Staff at North Center's Day Treatment Unit reported that, although outreach was permitted, it was rarely possible. The last home visit the staff could identify was several months ago.

One of the most glaring discrepancies between the Dixon program standards for case management and the centers' current procedures

arises when a client is hospitalized. At this point, when the client is most in need of support from his "clinician/case manager" and when the program standards for case management require the case manager to assist in resolving crises and to maintain contact with the hospital staff, the case manager is officially relieved of responsibility for the client. In other words, the client's community-based support system is cut off.

Other omissions by the centers which impinge on the case manager's ability to perform the job as required by the Dixon program standards are discussed in section III. One example worth citing here is the frequent lack of a comprehensive needs assessment and an individually tailored treatment plan based on the client's needs. Without these, it is impossible to imagine how a case manager could fulfill the obligation in the Dixon case-management standards to advocate on the client's behalf during the formulation of the treatment plan, ensure that it is implemented in a timely and appropriate manner and monitor the client's response to the specific treatment interventions.

Finally, the treatment-plan form itself discourages accountability of the case manager. It does not include a place to indicate who the case manager is or if the case manager attended the treatment-planning conference; there is no place on the form for the case manager to sign. Consequently, from the record it was often difficult to identify a client's case manager. In one case it seemed the client had been assigned to at least two case managers -- not the single accountable person the standards require; another plan stated that "all staff were responsible."

C. PATIENT ADVOCACY

The site-visit team observed that one staff member has been assigned at each center to carry out the responsibilities of patient advocates. In number, these resources may be sufficient. However, these staff have not been provided a job description, training, support or supervision.

On July 9, Marlene Ross met with Isabelle Smith and Phillis Copeland for approximately one hour to discuss their new positions as Patient Advocates. They informed her that they received a memo in

May which stated that, in addition to their other responsibility as Center Volunteer Coordinator (Ms. Smith at South Center and Ms. Copeland at North Center), as of May 11, 1982, each would have primary responsibility of serving as her center's patient advocate.

Other than this memo, a statement of general principles for a patient-advocacy system and a brief meeting between Ms. Copeland and the Mental Health Administrator prior to appointment, they received no other communication regarding the specifics of their new assignment. They were given no job description, no indication of their authority to resolve complaints, no indication of the specific parameters of their advocacy responsibility, i.e., whether they were to address client concerns regarding the center and/or client concerns regarding other mental health or human services agencies and/or the community. They were not told the chain of command or given procedures for resolving problems. They were not given access to transportation to make field visits; no explanations were provided about their recordkeeping responsibilities. They were unaware of any legal or other advocacy resources available to them. Neither woman had ever been employed previously as an advocate. They were not given any training, orientation or supervision for this job.

The site-visit team found it beyond comprehension how anyone could be expected to perform adequately under these circumstances. Still, both women were enthusiastic about their assignment. Although understandably overwhelmed, they are trying against all odds to do a responsible job.

During her visit at South Center, Ms. Ross asked six clients if they knew about the advocacy service. None did. Ms. Smith reported that no clients had yet been seen at South Center, for she is still trying to read about advocacy and understand her job. Consequently, she has not yet advertised the service in any way. Ms. Copeland has done some outreach at North Center; as of the date of the visit she had seen four clients since her assignment as an advocate.

In sum, while the District has designated two patient advocates, it has not developed a patient advocacy service. This seemed to the team a clear example either of the District's misconception about the purposes of the service or of its lack of commitment to provide it.

III. Lack of accountability and fragmentation of services among elements of the system impede continuity of care and often lead to hospitalization or to clients' disappearance from the mental health care system.

The absence of a comprehensive approach to client care is evidenced on both a systemic and an individual level. That the coordinated system required by the Dixon Consent Order is so poorly developed after two years of planning between the federal and District governments is especially troubling.

A. CLIENT TRACKING SYSTEM

One of the basic concepts underlying the Dixon Plan is the provision of a continuum of care. (Plan, p. 2) A fundamental principle guiding adoption of the Plan was to develop a coordinated system between St. Elizabeths Hospital and DHS. However, the site-visit team found no formal mechanism to keep track of clients in the hospital-community service system. The most glaring example involves a client's hospitalization.

If a CMHC client is seen at the Crisis Resolution Unit during the weekend, for example, and is sent directly to St. Elizabeths Hospital, the center is not formally notified. Unless the client misses a scheduled appointment or unless the staff hears from a family member or friend, days or even months may go by before the center discovers that one of its clients has been hospitalized. (Even when the center is notified, it terminates the client.) Consequently, it cannot initiate the series of immediate interventions by the staff who know the client best -- required under the Dixon program standards for case management and evaluation and assessment -- to handle the crisis in the least restrictive setting, to work closely with hospital staff to return the client to the community, to reassess the client's treatment plan and to make appropriate revisions in it in order to prevent future hospitalizations and crises. (For example, if a client is hospitalized whenever he lives with his mother, his treatment plan might be revised to obtain another supportive living arrangement for him.)

Furthermore, if a person is extremely psychotic when admitted to the hospital and he does not tell anyone that he is a client at a CMHC, the hospital has no formal means -- such as, for example, a

shared data bank -- to ascertain this important information. Consequently, the hospital does not receive from CMHC staff valuable information about the patient's difficulties, treatment responses and status in the community at a time when such knowledge is critical.

To add to the confusion, when the client returns to the center, if he does not or cannot tell the staff that he was hospitalized and they are not aware of it, they have no way of knowing what caused it and how to forestall it in the future.

In sum, one of the most disruptive events in a mentally disabled person's life -- extrusion from the community -- may for all practical purposes be a non-event to the very systems that could help avert it.

B. CONTINUITY OF CARE

Even within the individual components of the community mental health services system, there are no routine procedures to keep track of clients and assure continuity of care. For example, the CRU has no policies or procedures to notify its own CMHCs when a client in crisis is seen or when a client is referred to one of the centers. If a walk-in client is found to be registered at North Center, for example, the client is told to return to the center for ongoing care and may be given a slip of paper showing him how to get there. But the CRU is not required to notify the center that the client was seen and referred back or to transmit to the center important information about the client's problems. By the same token, there is no mechanism to assure that the client arrives at the service to which he is referred.

Team III reviewed records of seven clients referred by CRU staff to the North Center. Of these, three "never made it there." Two scheduled appointments, but didn't keep them (one rescheduled for a future time). Two were seen as "walk-ins" at the center; one of these had a psychiatric evaluation when she was seen, the other was seen only by a mental health technician and was not scheduled to be seen by a doctor for a month. In short, four of these seven cases fell through the cracks, two are in a tenuous situation, and

only one followed the course envisioned by Dixon program standards for crisis resolution.

In an attempt to assess continuity and coordination of care, the site-visit team examined 18 cases of clients recently terminated from the centers' rolls. (Eight of these were from the North Center; 10 from South.) Of the 18 closed cases, only three had an appropriate discharge plan and transfer of responsibility. (All three were moving out of the catchment area and appointments were made for them at their new mental health centers.) The other 15 records revealed a disjointed system. To illustrate:

A typical case -- A 55-year-old man with numerous hospitalizations and several admissions to and discharges from North Center was twice reported to be missing or not to have kept scheduled center appointments. Both times he was subsequently found hospitalized during the period of absence.

This high-risk client was being followed at approximately monthly intervals through September 1981. The last note in his record at that point was a one-line note saying that he was doing well. The next chart notation, in March 1982, said he was being terminated because he had had a "nervous breakdown" and had been hospitalized at St. Elizabeths. There is no history between September 1981 and March 1982 and no information in his record about what kind of "nervous breakdown" he had, what caused it, what was done about it, or what steps might be taken to avoid another in the future.

The charts of most of the terminated clients had no information about the client's status at the time they were terminated, to indicate how tenuous the client's situation might be. In some cases attempts had been made to contact the client, either by phone or in writing, but these outreach efforts were not sufficient. The face-to-face contacts that are an essential part of an effective outreach system and that are mandated by the program standards for case management were precluded by the two factors discussed in the previous sections: (1) the shortage of staff resources and (2) lack of comprehension of the critical role of assertive case management for severely disabled clients.

C. TREATMENT PLANNING

At the individual as well as the systemic level, absence of a coordinated, comprehensive approach to treatment planning and follow-through required by the Dixon plan is evidenced in the majority of individual charts and treatment plans reviewed at both centers.

The one notable exception was the geriatric program at North Center. Treatment plans and progress notes were found to be very good.

The program standards require that there be an individualized treatment plan for each client (see Section H, Service Records and Treatment Planning, and Section C2, Patient Evaluation/Assessment). This plan is to be developed by an interdisciplinary team composed of a psychiatrist and at least one other "core mental health professional" (a psychologist, masters-level social worker or registered nurse). It is also supposed to be developed in collaboration with the client.

At a minimum, the treatment plan must contain the following:

- (a) A statement of the precise nature of the client's problems and the portion being dealt with by the treatment plan;
- (b) The expected goals of the treatment, including the relationship of services to expected goals;
- (c) The manner in which residential and program placements will be met in the least restrictive setting dictated by the client's condition;
- (d) Documentation of how services will integrate the client into various elements of his social network;
- (e) Documentation of criteria for determining the achievement of treatment goals;
- (f) Documentation that the plan is updated periodically in collaboration with the client, significant others, and other appropriate agencies involved in assisting the client;
- (g) Signatures on the initial plan and all updates of the staff member(s) having primary responsibility for treatment, including the client's case manager and a list of other clinicians involved in treatment;
- (h) The client's signature indicating concurrence with the plan or, if a client cannot or will not sign, an explanation;
- (i) The name, title and, if outside the CMHC, the agency name and address and phone number of the person designated to have primary clinical responsibility for the client, as well as other treatment persons to be contacted in an emergency or when outside intervention is required.

(Program Standards, Section H-3, Service Records and Treatment Planning.)

With regard to progress notes, the standards require documentation of:

- (a) The time and duration of the services rendered;
- (b) Any efforts to assure that services needed from other agencies have been arranged for and provided;

(c) The reason a client could or would not make use of a service he needed or was offered;

(d) The options offered to the client for meeting specific needs and the client's preference;

(e) Changes in the client's level of functioning.

The progress notes shall be signed by the staff member responsible for the service rendered.

(Program Standards, Section H-4)

The site-visit teams found that most records were vague and did not meet the above standards. With few exceptions, the records were not specific enough in the various areas of a client's functioning to assist in developing a clear treatment strategy. They did not include historical specifics of treatment, i.e., what problems had been previously identified, by whom, where and how treated, with what results. They did not include recommendations for or notes of actual contacts with other agencies with which the patient might (or should) be involved, such as housing, entitlement or vocational agencies. Treatment interventions were rarely tailored to individual needs, and timelines to achieve specific treatment objectives were not spelled out. For example, a treatment plan might mention that a client's problem was "anxiety" and then suggest as the intervention "individual counseling." The record would not mention what was occurring in the person's life that made him anxious, the context of the anxiety, any problems the anxiety caused in the person's life or any interventions previously tried to help deal with the anxiety; it would not recommend a focus for individual counseling, whether it should be provided by a professional or nonprofessional, how intensive it should be and how long it should be tried before review. Several cases illustrate the problems:

Case 1 -- The client was referred by the court. In the evaluation, both the psychiatrist and the mental health technician concluded that the patient "doesn't seem to have much of a mental health problem." They did not understand why the person was referred by the court, but the record contained no indication of any contact with the court to clarify or better understand the client's situation. Nevertheless, the client was given a diagnosis of "Personality Disorder, Indifference [sic], Psychosocial Stress, Independence." The individual treatment plan consisted of two words: "Individual therapy." There was no record that the person was seen in therapy. Following a period of non-attendance, the final entry was a note that he was "discharged to self."

Case 2 -- This case shows what happens in a system of care that is not oriented toward individual needs. This case involved a client who came to the South Center with a

known history of alcohol-related problems. According to the chart his chief complaint was of physical problems. No physical examination, however, was recommended or performed. The client also told the staff that his wife of 15 years and his two children had just left him. The treatment plan on the chart read as follows:

Strengths: Physically well
Family Support

Client Goals: Improve present functioning

Staff Goals: (None listed)

Specific treatment

modalities: Psychotherapy - short-term
Chemotherapy

Concurrent Medical Problems: (None listed)

The client was given a psychotropic drug. He never returned. No outreach was made.

The team visiting the North Center randomly selected the charts of four patients attending day treatment. They reviewed the charts in some depth, then discussed them with the day-treatment staff. Most of the information was vague. The team found it very difficult to get a sense of any history of past treatment, agency involvement, hospitalization, who the patient was, how he spent his time, what problems he had, what had precipitated hospitalization and other kinds of instability in the past and what might be done to prevent recurrence. Fortunately, interviews with the staff revealed that they often knew the client much better than the records indicated. But such information was seldom converted into a coordinated treatment strategy designed to prevent crises. Cases that were reviewed highlight this problem.

Case 3 -- Day-treatment staff had been working closely with a client and her mother, with whom the client lives. The client was hospitalized through the CRU on a weekend. But the CRU staff did not understand why the client was hospitalized, what stresses were involved, the extent to which the mother contributed to the problem and what alternatives might be found. Now the client is out of the hospital and again living with her mother, but the day-treatment staff working with her still do not know what caused the last hospitalization or how to avert another crisis.

Case 4 -- This case involved a client suffering from depression, who never really connected with the day-treatment program despite several phone calls and letters by day-treatment staff. The available information did not make clear why he was referred to the Day Treatment Unit in the first place and what he needed from it. It was therefore impossible to assess how much energy the staff should devote to getting this client into the program. Was day treatment a beneficial but not critical service for him, or could it be potentially lifesaving? What would happen if he did not participate in the program and what alternative supports did he have without the program?

These issues were not addressed in the records and could not be explained by the staff.

At the South Center, of 21 "active" records reviewed, four (19%) contained no treatment plan. (The actual form was there with the client's name on it, but it was blank.) Similarly, at North Center, the team found no treatment plan in six (23%) of the 26 "active" records reviewed. In another three cases the most recent treatment plan appeared to be from seven to 10 years old. (This was determined by the chronological order in which the plan appeared in the record, since two of the plans were undated.)

The team at South Center requested and was given 25 treatment plans drawn at random from the active files. (These were in addition to the 19 active records they reviewed.) Most treatment interventions appeared to be nonspecific to the client's particular problems; chemotherapy and individual (or supportive) therapy are clearly the treatments of choice. The 25 plans revealed clients with widely varied treatment goals -- for example, "avoiding stress," "seeking employment," "improving financial situation," "improving present level of functioning," "decreasing drinking" and "increasing socialization." Yet in 22 of these cases (88%) the only specific treatment modalities recommended were individual (supportive) therapy and/or chemotherapy. Conspicuously absent were recommendations for case-management services, vocational-rehabilitation programs, socialization programs and daily living-skill programs -- services which many Dixon clients need and for which the Dixon Plan provides throughout.

In five of the 25 plans (20%), the only treatment goals were "continued treatment" or "get involved with the program." Obviously, such generalized statements are not conducive to identifying and meeting specific client needs.

D. ACCOUNTABILITY

The treatment-plan form itself does not reveal which staff members participate in the actual treatment planning, although, as described above, the Dixon program standards require such accountability. The majority of records reviewed suggests that the planning is not a interdisciplinary team effort, as Dixon standards for

Patient Evaluation/Assessment require. This is not surprising, considering present professional staff-patient ratios --for example, the equivalent of only one full-time social worker for every 488 clients, one full-time psychologist for every 651 clients and one full-time registered nurse for every 244 clients, as the South Center staffing patterns reveal. At these levels, interdisciplinary assessment and treatment planning for individual clients is simply not possible.

CONCLUSION.

To summarize, the site-visit team has reached three major conclusions from its July 7-13 evaluation of the District's Community Mental Health Centers. First, the scarcity of resources in the centers precludes development of the community-based system mandated by Dixon. A direct relationship exists between the resources available to a community-based mental health system and its ability to stabilize and assist severely disabled people. Yet the District's elimination of almost 100 mental health positions last summer left its community centers with such severe staff shortages that they cannot provide the services needed by the Dixon class.

Shifting the primary locus of care from the hospital to the District's community mental health system, as the Dixon Implementation Plan mandates (Plan, p. 2), cannot occur without adequate resources for community-based services. The Dixon Plan provides for the development of a comprehensive system of community care, but the District has insufficient resources to do so. Until the financial incentive exists and the resources are available to provide needed services in the community, many chronically and severely mentally disabled people will continue to be hospitalized and will remain unable to cope with community life once released.

Second, key community services are not now designed to meet the needs of many Dixon class members. A growing body of literature has identified specific needs of severely disabled chronically mentally ill persons that must be met to stabilize their condition and enable them to live in the community. Meeting these needs requires the use of carefully designed service-delivery strategies and the targeting

of resources. This is not to suggest that only one model of treatment is acceptable. A range of modalities has been used successfully in different parts of the country. The one characteristic these models have in common, however, is that they address, through assertive outreach and follow-through, the practical problems that arise as a result of the passivity and limited coping skills of the severely impaired client. Two of the most important services for such clients, required by the Dixon Plan -- (1) an intensive and comprehensive case-management system and (2) effective crisis resolution -- have not been adequately developed. Neither has patient advocacy.

Third, the Dixon Plan requires and experts in the field agree on the need for a comprehensive and coordinated approach to client care. The various components of the system -- the community mental health centers, the Crisis Resolution Unit and St. Elizabeths Hospital -- operate without accountability to each other and with little formal communication or interaction. Further, individual needs assessments and coordinated treatment plans, required by the Dixon program standards, are often inadequate or nonexistent.

It is the unanimous opinion of this site-visit team that the existing community mental health system is seriously deficient in its ability to meet the needs of a large number of Dixon class members and that, with its present resources, it cannot provide the comprehensive, coordinated services mandated by Dixon.

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* Although Drs. Bevilacqua and Mills participated in the site visits and provided information on which this report is based, they have not had an opportunity to review the report in its final form because they are on vacation.

DIXON IMPLEMENTATION MONITORING COMMITTEE'S REPORT TO THE COURT: CLIENT CARE AT
SOUTH COMMUNITY MENTAL HEALTH CENTER

INTRODUCTION

In July 1982 a team of eight mental health professionals conducted a comprehensive site visit and evaluation of the District's community mental health centers. The team's primary objective was to determine whether the centers could adequately serve clients who were to be discharged from St. Elizabeths Hospital to the District's responsibility under the April 1980 Consent Order and Plan in Dixon v. Harris.

In February 1983 the Dixon Implementation Monitoring Committee (hereinafter "the committee") began monitoring a random sample of 100 clients who had been transferred from the hospital's outpatient rolls to the District through the joint-dispositional-conference process. Although this study is just over half completed (57 of 100 cases have been reviewed), the committee hereby submits an interim report for this Court's review in the context of its current examination of the District defendants' implementation of the Dixon Consent Order and Plan.

The purpose of this review is to determine whether the three major deficiencies in patient care found by the site-visit team last July still exist. We conclude that they do.

The assessment submitted by the Dixon Committee to this Court in September 1982, based on the findings of the site-visit team, has been confirmed: the District's mental health care system is not able to fulfill its obligations under the Consent Order and Plan to many chronically mentally ill clients transferred from St. Elizabeths Hospital. A significant number of clients in the March 1983 survey group have failed to receive needed services, have dropped out of treatment or have been rehospitalized.

The reasons are fundamental: (1) a lack of continuity of care, leading to poor treatment coordination and fragmentation of services; (2) an absence of comprehensive case management services required by the Dixon program standards; and (3) an inability to resolve crises in a timely manner using the least restrictive alternative. These are the same major deficiencies in client care found by the site-visit team in July 1982.

On the basis of its findings, the site-visit team unanimously concluded last August that the District "system does not adequately serve people whose severe mental health and coping problems require intensive outreach and follow-along services to prevent hospitalization or other serious problems. It is clearly not prepared to serve such clients who are scheduled to be transferred from St. Elizabeths Hospital to the District's responsibility under the Dixon Consent Order." (July 1982 Site-Visit Report, submitted August 12, 1982, p. 1.)

CLIENT PROFILE AND SURVEY METHODOLOGY

The client-monitoring survey was conducted by Gail Marker, M.S.W., staff coordinator of the Dixon Implementation Monitoring Committee, assisted by Suzanne Bergeron, Harry Schwarz and Chainie Scott, graduate students in social work who are interns with the committee (hereinafter referred to as "the surveyors").

Leonard I. Stein, M.D., committee member, provided consultation in the design of the study and interpretation of the clinical data. He reviewed the findings in this report and wrote the conclusions based upon them.

The survey sample consists of 100 clients transferred from the outpatient rolls of St. Elizabeths Hospital to the District. Of these, 57 were transferred to South Community Mental Health Center (SCMHC); 43 to North Center (NCMHC). These clients were selected by a random-numbers table from a total population of 246 clients transferred from the hospital to the District between February and October of 1982, prior to the moratorium. The full sample represents 40% of all Dixon clients discharged through the joint dispositional conferences mandated by the Consent Order and Plan (Plan, Section VII, p. 61).

As of March 16, 1983, the cases of the 57 people transferred to South Center had been reviewed. Five of these, however, could not be included for purposes of data analysis. Although the list from St. Elizabeths Hospital showed these five clients as discharged to SCMHC, the surveyors found that four were never formally transferred. Consequently, SCMHC has no records for these clients. The fifth client was formally transferred to SCMHC but the surveyors

reported SCMHC staff as saying, "He was admitted, but walked out the same day, so no record was opened."

The findings discussed here, then, are based on a completed sample of 52 cases. The sample represents 20% of the total number of clients discharged to the District, which is a sufficient number of cases on which to base meaningful conclusions.

The 52 clients have the following characteristics: 92% are black; 58% are male; 75% are between 20 and 59 years of age; 87% live with relatives or in a foster home (only 8% live on their own); 89% have no spouse; 71% have a primary diagnosis of schizophrenia (another 27% have a diagnosis of some other type of major psychosis); 64% have some type of medical problem (40% of these have more than one medical problem); 48% have less than a high school education; 78% are unemployed; 79% are dependent on SSI or public assistance for their income; 88% have been hospitalized three times or more; 48% have been hospitalized one or more times in the past two years.

In short, the characteristics of the survey population are typical of people with chronic major mental illness. They indicate clearly a need for specially designed, intensive therapeutic and support services -- the very range of services mandated by the Dixon Consent Order and Plan. (Site-Visit Report, p. 14.)

SURVEY FINDINGS

The study consists of a comprehensive review of clinical records at the District CMHCs and at St. Elizabeths Hospital, using a detailed questionnaire modeled on the one used by the July 1982 site-visit team (see Attachment 1). The information collected comes entirely from facts in each client's record. In most instances, the completed forms contain direct quotations from the record.

The data were collected between February 8 and March 16, 1983, providing up-to-date information about progress made by the District in correcting the major deficiencies found at South Center last July by the site-visit team. The survey's findings with regard to continuity of care, case management and crisis resolution follow.

I. CONTINUITY OF CARE

"One of the basic concepts underlying the Dixon Plan is the provision of a continuum of care." (Plan, p. 2.) Without such continuity of care, Dixon clients will not be able to receive the treatment they need. The July 1982 site-visit team unanimously found "fragmentation of services at both individual and systemic levels -- a system so disjointed that many clients cannot cope effectively in the community and as a result disappear from the mental health system, even though they may need its services, or are hospitalized." (Site-Visit Report, p. 2. See also pp. 31-41.)

The March 1983 survey corroborates these findings. The mental health system currently serving District of Columbia residents still cannot provide the continuity of care needed by Dixon clients. As a result, they continue to be harmed, as the following findings and case examples demonstrate.

A. Joint Dispositional Conferences

The Dixon Plan requires that a joint dispositional conference be held before a client is transferred from the hospital rolls to the District. The joint conference is a significant event in the transfer of responsibility from one system to another. Even more, it is very relevant to the content of a client's treatment.

The various hospital divisions use different techniques to transmit information to the CMHC about a proposed transfer client, before the joint dispositional conference. Some of the SCMHC records reviewed included the client's most recent hospital treatment plan. Some had psychiatric, medical and social assessments performed by the hospital in preparation for the dispositional conference. Other files contained hospital progress notes, and still others had a summary fact sheet from the hospital about the client's treatments and need for services.

No matter what its form, such written information is important to the CMHC staff. However, as described in the Dixon Plan, an actual conference is required "to obtain agreement on a comprehensive aftercare plan and to assure continuity of care during each patient's transition from SEH convalescent leave to MHSA outpatient status." (Plan, Section VII, at 61-62.)

Yet none of the 52 SCMHC records surveyed in March 1983 had adequate information about the conference:

1. Decision-Making Process

Surveyors could not identify what treatment and transfer problems had been raised and what important decisions, if any, had resulted from the conference.

2. Transfer of Responsibility

Surveyors could not find the date the client was formally discharged from the hospital's rolls to the center and therefore could not ascertain how SCMHC staff knew at what point they bore the clinical responsibility for the client.

3. Conference Date

Surveyors could not find the date of the actual conference.

4. Client Participation

Surveyors were unable to determine whether the client was present at the conference and what concerns he expressed.

5. Conference Participants

Surveyors could not ascertain what members of the CMHC staff were present at the conference and therefore could not assess whether there was continuity between the people who attended the conference and the people who would then treat the client.

Some of this information was ultimately found in the hospital's records. When the surveyors asked SCMHC staff why it was unavailable in their own clinical records, SCMHC staff answered that it was not the responsibility of the CMHC since the client was still on the hospital's rolls at the time of the joint dispositional conference; SEH was therefore responsible for keeping this information. The information was recorded by CMHC staff during the conference, the staff member stated, but was kept in separate administrative records. This important history simply never became part of a client's clinical record.

Two examples illustrate the breakdown in continuity of care that occurs when CMHC staff do not monitor the transfer process.

Case 17 :^{1/} A 35-year-old man with a primary diagnosis of chronic schizophrenia was conferenced for trans-

1/ Survey numbers assigned to each case are used instead of initials to protect the clients' identity.

fer to SCMHC in December 1981. A dispositional conference was held and the necessary paperwork was sent to SCMHC. An appointment was scheduled at SCMHC in January and in February the client was discharged from SEH. In March 1982, he was rehospitalized.

All of the above information was found only in his SEH file. No information was written in his SCMHC record until October 1982 -- eight months after he was transferred for treatment. Further, there is no evidence that SCMHC staff ever tried to find him. Apparently, he returned to SCMHC on his own in October 1982.

The client has serious treatment needs; he decompensates without medication and he recently lost his place in a halfway house after living there for five years. But as of March 1983, there was no treatment plan in his SCMHC file.

Case 185: This client, a 48-year-old man with a primary diagnosis of chronic schizophrenia, had a joint dispositional conference in April 1982 and was scheduled to have his first appointment at SCMHC in May. The first note in his CMHC record, however, is dated nine months later. It states: "This patient is very well known to this clinic. Came in May 26, 1982, but walked out. ... Patient talking to himself and appears to be hallucinating."

With no CMHC record for this client from May through December, it is impossible to tell what happened to him at the critical transfer point. Since his admission to SCMHC in December 1982, the client has kept only two medication appointments. His SEH record states that he never missed appointments at the hospital's outpatient department and that he only "remains delusion-free by taking his medication as scheduled." However, because he refuses to see a particular doctor, he does not receive essential medications at SCMHC. And there are no recorded attempts by SCMHC staff to overcome this barrier to his treatment.

B. Treatment Planning and Follow-Through

The July 1982 site-visit team found that "absence of a coordinated, comprehensive approach to treatment planning and follow-through required by the Dixon plan is evidenced in the majority of individual charts and treatment plans reviewed at both centers." (Site-Visit Report, p. 35.)

The team found that "most records were vague and did not meet the Dixon standards" with regard to setting timelines for achieving treatment objectives, involving the client in the planning process, specifying services to be provided and recording services actually provided and the client's response to them. (Site-Visit Report, p. 36.) Furthermore, the July 1982 site visit found that even when information was documented in the record it "was seldom converted into a coordinated treatment strategy designed to prevent crises." (Site-Visit Report, p. 34.)

The March 1983 survey makes it clear that the treatment plan-

ning and follow-through required by the Dixon Plan and program standards still do not occur at SCMHC, and that Dixon clients are being harmed by the absence of these important elements of the continuum of care.

A case example illustrates:

Case 146: This client is a 23-year-old man admitted to SCMHC in November 1982. There is no treatment plan in his CMHC record, so it is impossible to know what services he should have received. His last appointment was November 29. No subsequent progress notes appear in his SCMHC file. There are no documented outreach attempts of any nature. Although his case is listed as "active" at SCMHC, no one has seen this client since November.

Examination of his SEH record shows that this client has multiple needs -- medication, observation for substance abuse and job referral to vocational rehabilitation; he has family financial problems and poor social support. Until he was transferred to the District's responsibility he had "faithfully attended outpatient clinic."

The March 1983 survey found continuing violations of the Dixon standards for treatment plan monitoring and follow-through in a number of areas.

1. Timelines

In the treatment plans of 90% of the clients surveyed (47 of 52 cases), the March 1983 survey found no timelines for reaching specific treatment objectives, as required by the Dixon Plan and program standards for service records and treatment plans. (The remaining five clients' records contain no treatment plans at all.) In 71% of the cases (37), the amount or intensity of a service needed is not identified on the treatment plan. As a result, there is virtually no accountability.

2. Client Involvement

In 40 records (85% of the plans), the March 1983 survey found no indication that the client had been involved in the development of his treatment plan, as is required by the Dixon Plan and program standards for service records and treatment planning. Although a new treatment-plan form, developed by MHSA after the July 1982 site visit, includes a place for the client to sign, indicating his participation in the plan's formulation, not one of these 40 forms included the client's signature.

3. Medications

In 47% of the plans (22 of 52 records), medications are de-

scribed on the plan only as "chemotherapy" or "medication." The drug's name and the amount and frequency of dosage are not identified. It is thus impossible to tell what drugs these 22 clients should be receiving at SCMHC.

The Dixon standards for service records and treatment planning require that each record have an "identifiable Drug Use Profile wherever drugs are administered or monitored, which is begun at time of admission and reviewed regularly to assure that changes in medications and dosages are noted."

The Drug Use Profile shall include: (a) A history of the prescribed and non-prescribed drugs for the previous six months which records the names of the drug products and the dosages, routes, schedules, and conditions for which the drugs were prescribed or taken; (b) a history of drug allergies and sensitivities; (c) a listing of the drugs currently prescribed; (d) the dates and reasons for discontinuance of drug therapy. (Dixon Program Standards, Service Records and Treatment Planning.)

The March 1983 survey found nothing resembling a drug profile in any record.

Furthermore, the doctors' orders for medications found in the records are not countersigned and progress notes do not always mention medication, so it is often impossible to tell whether a client ever picked up a prescription or received the medication at SCMHC.

In nine cases (17%), the March 1983 survey found that SCMHC, without listing any reasons, discontinued drugs, prescribed new drugs or substantially increased or decreased the medication a client had been receiving. Side effects were observed in three of these cases. In two, extrapyramidal symptoms (a severe side effect often associated with overuse of psychotropic medication) were recorded.

Case 52 had been maintained on Prolixin shots every four weeks at St. Elizabeths, but when she first came to SCMHC, her medication was doubled: She was given the same dosage of Prolixin every two weeks. SCMHC staff observed her "shaking constantly" and changed her shots to once every three weeks. The shaking diminished but did not disappear for some time because she was still receiving substantially more medication than at SEH. Her record includes no explanation for the increase.

Case 38 had also been maintained at St. Elizabeths on about half the amount of Prolixin that SCMHC staff gave him after his transfer. Again, shaking was observed, and again there is no explanation for the increased dosage.

In the third case, medications were substantially decreased by SCMHC staff, with no explanation, and the client decompensated. (Case 43 is discussed in detail in Section II, Case Management.)

4. Service Records

The March 1983 survey did not find in a single client's progress notes any record of the time and duration of a specific service (e.g., individual therapy, drug therapy or day treatment), even though such documentation is required by the program standards for service records and treatment planning.

5. Implementation of Treatment Plans

The March 1983 survey found a wide gap between the services identified as needed on clients' treatment-plan forms and the services actually provided by SCMHC. In 52% of the records (27 of 52), surveyors could find no indication that the client received some of the services listed as needed in his treatment plan.

Furthermore, even treatments that are provided usually do not comply with the Dixon standards. For example, "Individual Therapy" is documented in some clients' records as occurring once or twice a month -- usually around the time a client gets his medication -- but it is never recorded as occurring 40 times a year, 50 minutes per session, as required by the program standards. "Day Treatment" is often shown as occurring several times a month, but never several times a week in four-hour sessions as the standards require.

6. Follow-Through

The March 1983 survey found that 30 of 52 clients (58%) had missed needed treatments at SCMHC for a significant period of time. In only 6% of those cases (2 of 30) were telephone calls consistently made soon after missed treatments in an effort to re-engage the client in treatment. In eight of the cases (27%), such outreach calls were made as late as 10 months after the client had last appeared for treatment (most calls were made two to three months after the last visit). Twenty of the clients' files (67%) have no record at all of attempted outreach.

7. Reassessment of Treatment Plans

The March 1983 survey found no evidence that treatment plans were reassessed after hospitalization, as required by the Dixon standards, for any of the eight SCMHC clients rehospitalized for

psychiatric problems. (This and other failures by SCMHC staff in treatment-plan monitoring for hospitalized clients are discussed in Section III, below, on crisis resolution.)

C. Hospitalization and Crisis Resolution

The July 1982 site-visit team concluded that one of the most glaring gaps in continuity of care occurred when clients were hospitalized. CMHC staff had no formal mechanisms to keep track of center clients who were rehospitalized, to ensure close contact with hospital staff in order to effect the client's timely return to the community, to obtain critical information about the client's response to hospitalization and to reassess and, if necessary, revise the treatment plan in order to provide more intense or different treatment interventions to avert future hospitalizations. (Site-Visit Report, pp. 31-33.)

Hospitalization, as the site-visit team concluded in July 1982 (on p. 33 of its report), is a non-event to CMHC staff. As described in Section III, below, on crisis resolution services, the March 1983 survey revealed that when a South Center client is hospitalized, continuity of care as required by the Dixon program standards breaks down completely.

The March 1983 survey found that SCMHC staff were not aware until months later, if at all, that three of the eight center clients rehospitalized for psychiatric reasons were at St. Elizabeths Hospital. While this is a gross deficiency, it is not surprising. Although the three clients failed to appear at the center for needed treatments, no attempts to reach them were documented in their records. A January 1983 progress note for one of these clients states: "Patient phoned today requesting appointment for medications. When questioned as to his whereabouts since October 1982, client stated he had been at SEH." (Case 227).

Although the program standards require it, the records show no SCMHC contacts with the eight clients hospitalized for psychiatric problems throughout their rehospitalization. Only one record shows any attempt to effect timely and appropriate outplacement by working closely with hospital staff, as required by the Dixon standards -- and this contact was broken one week later, although the client

remained hospitalized for seven months. In none of the eight CMHC records was there information from the hospital concerning the client's course of treatment in the hospital and his hospital discharge plan.

Similarly, when the Crisis Resolution Unit (CRU) is involved with a client, reports from the CRU should appear in the client's CMHC record, indicating assessments and findings by the CRU, specific crisis interventions (if any) provided (e.g., rapid tranquilization or home visits) and specific less restrictive alternatives that were tried or considered. The March 1983 survey found no such reports. In the two cases where SCMHC used the CRU, the only record of the CRU'S involvement is the final outcome: the client's hospitalization.

D. Discharges

In an attempt to assess continuity of care, the July 1982 site visit examined 18 cases of clients terminated from the centers' rolls. They found that only three of these had been discharged appropriately. (Site-Visit Report, p. 34.)

The March 1983 survey found that in the 11 months from March 1982 to February 1983, SCMHC had discharged from its rolls and its responsibility seven of the 52 surveyed clients (14%). Each of these clients has had from three to 14 hospitalizations. Five have been hospitalized during the past two years and four had been living in the community one year or less at the time of discharge. In sum, like the other clients in the sample (and in the Dixon class), they have a history of multiple and recent hospitalizations.

Four of these discharges are grossly inappropriate. Case 59 was discharged "to self" for failing to keep his medication appointments, although he was found to need the medications. Case 201 was discharged because she was hospitalized -- the very opposite of the clinically mandated range of services required under Dixon for hospitalized clients. Case 38 was discharged "to self" as no longer needing treatment, although he had been found to decompensate without it. And Case 92 was discharged "to self" because he had "no interest to continue treatment at SCMHC." Although the client has had multiple hospitalizations and has many treatment needs, includ-

ing drug abuse and alcohol abuse, SCMHC records evidence no consistent efforts to keep him in treatment.

Two more of the discharges may be inappropriate. Further investigation is needed to be sure, but there is reason for concern. One client (Case 203) who is on psychotropic medication was discharged to the care of a general practitioner employed by a large foster home (although the Dixon program standards for drug therapy specifically require that treatment of a client with psychotropic medication be administered by a psychiatrist, not a general practitioner). The other client (Case 143) was hospitalized for psychiatric problems, was sent to a local nursing home and was then discharged from SCMHC's rolls. (SEH assumes continuing psychiatric responsibility for its clients who are placed in nursing homes; surely the District should do the same.)

The discharge in Case 64 was appropriate; the client had died.

In view of all these clients' histories of repeated hospitalization, the total break in continuity of care represented by discharge -- occurring less than one year after transfer to the District from the hospital -- places these clients in jeopardy.

Two case examples illustrate these concerns:

Case 59: This client is a 29-year-old man with a primary diagnosis of schizophrenia, admitted to SCMHC in April 1982 after four hospitalizations, the last less than 18 months earlier. He was admitted at that time for trying to attack family members with a knife. He has a history of assaultiveness.

According to his SCMHC treatment plan, he needs Prolixin injections every two weeks, supportive counseling, help in finding a job, possible legal referral to establish visiting privileges with his son and a place to live.

SCMHC notes show that he began to miss medication appointments in early September 1982. By January 21, 1983, he was six weeks overdue for an injection. The last recorded attempt to reach him was on December 3.

On January 21, staff spoke with client on the telephone and set up an appointment for January 28. On January 28, he's listed as "No show -- will discharge for failure to follow through with prescribed treatment."

Considerable effort by SCMHC staff is necessary to keep this client involved in treatment. Apparently, they decided not to continue the effort. The final entry is a discharge summary on January 31: "Patient has a long psychiatric history of multiple hospitalizations. Started treatment here, but chronically does not keep appointments. Has not been to this clinic since November 26. Was receiving supportive therapy, prolixin every two weeks.

Condition on Discharge:	Undetermined
Discharged to:	Self
Reason for Discharge:	Failure to follow through with prescribed treatment"

Case 28: This client is a 35-year-old man with a primary diagnosis of chronic schizophrenia, admitted to SCMHC in March 1982. He had three hospitalizations, the last one in January 1981, when he was admitted for making threatening gestures toward his mother. He still lives with her. He has been able to hold part-time jobs for about one year. According to a January 1982 note in his SEH record, "Patient has been quite reliable in following through with his outpatient appointments and prescribed medications, voicing acceptance of his need for medication for some time." His CMHC plan states that he needs Prolixin once a month and individual therapy.

A June 17, 1982 note in his SCMHC file states: "Patient wonders how much longer he should continue medications. I indicated he should continue on the present medication dosage in view of history -- two relapses after discontinuing medications."

Nevertheless, there is no record that anyone at SCMHC has talked with the client since October 20, 1982. The only other entry in his file appears on February 7, 1983. It is his discharge summary: "Client transferred from SEH for follow-up -- functioning very well at time of transfer. Course of treatment -- client was seen monthly for supportive therapy and prolixin. Condition on discharge -- asymptomatic, functioning well. Disposition -- Discharge to self by mutual agreement."

It is difficult to imagine on what basis the conclusion was reached that the client needs no further treatment. There are no notes to verify when and if discharge was discussed with the client and how he now plans to meet his medication needs in order to prevent decompensation and hospitalization.

Discharging such clients may relieve some of the burden on overtaxed staff, but clearly it places clients at high risk of repeated hospitalization and decompensation.

II. CASE MANAGEMENT

In its August 1982 report, the site-visit team set out the minimum requirements for case management, as described in the Dixon Program Standards. These standards assign the following types of job responsibilities to case managers:

- Monitor whether the client is actually receiving the services called for in the plan, through the client's own reports and by making periodic site visits and by consulting with staff providing each service;

- Aid the client's transition from one service program to another (e.g., by offering to accompany him to a new service until he feels comfortable there);

- Assist the client in claiming public entitlements;

--Act as a resource referral for the client by identifying all mental health, residential and other services to meet a need identified in his Individual Treatment and Community Services Plan and accompany the client, if needed, to help him use these resources;

--Assist the client to find and adjust to suitable housing, and if needed, to negotiate leases, purchase furnishings and household items and find compatible roommates;

--Assist the client to find a suitable job, learn transportation routes, open a bank account and manage money;

--Coordinate with residential and other staff who are providing rehabilitative care to the client;

--Assist the client with crisis resolution by reassessing the client's treatment plan in the event of his hospitalization, by maintaining close contact with a hospitalized client and working closely with hospital staff, and by assisting the client to maintain community ties in order to facilitate his return to the community. (Site-Visit Report, pp. 23-4).

Each Dixon client is entitled to receive such services, as prescribed in his individual treatment plan.

The July 1982 site-visit team found "no evidence of comprehensive case management in the treatment records they reviewed." (Site-Visit Report, p. 27.) The team concluded that this was one of the most serious deficiencies in client care: "If the case manager cannot connect the client to or actually provide the services he needs to remain stable in the community, the client is in jeopardy." (Site-Visit Report, p. 25.)

In the majority of cases reviewed by the March 1983 survey, there is still no evidence of comprehensive case management. The major deficiencies found by the site-visit team still exist. These are discussed below.

A. Accountability

The July 1982 site-visit team found that "the treatment-plan form itself discourages accountability of the case manager. It does not include a place to indicate who the case manager is. ... Consequently, from the record it was often difficult to identify a client's case manager." (Site-Visit Report, p. 29.)

In March 1983, the surveyors were unable to identify from the records the case manager assigned to one-third of the clients (18 of

the 52). Since the words "case manager" do not appear anywhere on the revised treatment-plan form developed by MHSA after the site visit, the surveyors had to try to ascertain the identity of the case manager from other information on the treatment-plan form, from lab reports, from transfer notes and from admission notes.

The absence of an identifiable case manager clearly places a client in jeopardy. For six of the eight SCMHC clients rehospitalized for psychiatric reasons (75%), the identity of the case manager was unrecorded.

B. Monitoring and Follow-Through of Treatment Plans

One of the most important responsibilities of a case manager is to "monitor whether the client is actually receiving the services called for in the plan ... [and to] document in the client's progress notes the findings and recommendations of this monitoring." (Program standards for case management, Section C-2.) Additionally, the program standards for evaluation and assessment (Section C-2) require re-evaluation of the client's progress and revision if necessary of the treatment plan "[a]t least every six months. ... More frequent reviews may be requested by the case manager or may be required because of a crisis incident" (emphasis added).

A glaring area of noncompliance with the above standards, found by both the July 1982 site visit and the March 1983 survey, was the utter failure by CMHC case managers to monitor and reassess a client's plan when rehospitization occurred. This is discussed in detail in Section III, below.

C. Outreach

The site-visit team concluded that the District's CMHCs were set up to serve adequately only the less disabled of their clients -- those with few problems who are relatively stable and whose major treatment needs are medication and checking in about once a month to let the center staff know how they are doing. The July 1982 site visit found that CMHC "staff seem to know these clients well, and when one misses a medication appointment, will try to get in touch with him immediately." (Site-Visit Report, p. 7.) However, the

site-visit team concluded that "[t]here is a great difference between providing outpatient psychotherapy for people who can meet their own needs with reasonable stability and providing for the treatment of a large group of chronically mentally ill patients who have demonstrated by repeated hospitalizations and repeated crises that they are unable to cope effectively without intensive, specially designed supportive and therapeutic services." (Site-Visit Report, p. 14.)

One of the most important of the "intensive, specially designed supportive and therapeutic services" needed by many Dixon clients is outreach.

The July 1982 site visit found that at both centers "outreach capability was particularly deficient." (Site-Visit Report, p. 28.) Only a few attempted home visits were recorded. The March 1983 survey found nothing changed. The records showed home visits to only four clients.

The site-visit team noted in July 1982 that "in some cases attempts had been made to contact the client, either by phone or in writing, but these outreach efforts were not sufficient." Site-Visit Report, p.35.)

The March 1983 survey found that 93% of the clients (28 of 30) who had missed needed treatments had not been called until from one to 10 months afterward -- if at all. Furthermore, when a client did not respond, telephone outreach was not followed up quickly with the face-to-face outreach needed to re-engage clients in treatment.

Twenty-one of the 30 clients who missed needed treatments -- as evidenced by notes so stating in their records or by the absence of progress notes documenting services provided -- were among the 34 clients who had identifiable case managers. (The missed treatments usually involved medication, individual and group therapy and/or day treatment.) Timely phone calls to ascertain what had happened and re-engage clients in treatment were documented in only two cases. Calls were made to seven clients from one to 10 months after the client had last appeared for needed treatment. (Most calls were made two or four months later.) No outreach of any kind was documented for the remaining 12 of the 21 clients.

Similarly, of the 18 clients without identifiable case managers, nine had missed needed treatments. Only one phone call is documented, to one of these clients -- made three and a half months after the client's last appearance at the center. No outreach attempts were recorded for the remaining eight clients.

The March 1983 survey clearly reveals that case managers still do not fulfill one of their most critical responsibilities: monitoring implementation of a client's treatment plan and revising the plan when current interventions are not working. While the consequence of poor monitoring may not be deterioration or rehospitalization the first time the client misses a treatment, prolonged neglect by case managers surely places clients at a high risk of harm and, eventually, of unnecessary rehospitalization.

Three case examples illustrate the consequences:

Case 170: This client is a 58-year-old woman, admitted to SCMHC in June 1982. Her CMHC treatment plan states she should receive psychiatric medication and counseling, both at monthly intervals. She should also receive medications for hypertension. After the client came in for treatment in June and in July, no further progress notes were made for three and a half months. In early December, the client reappeared. There is no information in her SCMHC file why she was absent or what had happened to her during this period. No outreach attempts of any kind are documented. The client had two more appointments. As of March 15, when this record was reviewed, the client had again been absent from treatment for almost two months, as indicated by the absence of progress notes. There is no explanation what has happened to her. No outreach of any kind is documented.

Standing drug orders were left for the client during her absences, but there is no indication that she came in for the medications.

Case 154: This client is a 28-year-old man, admitted to SCMHC in June 1982. According to his CMHC treatment plan, he should receive Prolixin injections every two weeks. His SEH records show that as an outpatient he kept his medication appointments regularly. His first injection at SCMHC was in early June. He did not appear again until late July, when a note states: "Patient called today asking for an appointment. ... I tried to call him twice -- once in June and July, but I could not get an answer." No home visit was documented. No letter was written. There was no record where the client had been or what would be done to get him back on a medication schedule.

Fortunately, the client returned on his own in July and received his injections through September.

He then failed to appear for over a month and a half, with no explanation of his absence in his record. No outreach was documented. The client returned on his own in early November. He received two more injections. He then disappeared for another month and a half, again without recorded explanation or outreach. In January the client received an injection, then disappeared again. As

of March 15, almost two months later, there are no further notes in his chart and no outreach has been documented.

Case 86: Two home visits were made to the client in this last example. However, both occurred months after the client had last appeared for treatment and on neither occasion was the client at home when the visit was made. This 62-year-old man was admitted to SCMHC in May 1982. The admission note in his CMHC record states: "Patient has history of irregular visits for medication, when not taking medication he becomes psychotic ... will follow client closely."

The client was at SCMHC for medication in early June. There is no indication that he came in for treatment during the next three and a half months. In late September, the case manager noted that he called the client to come in for medication. Several days later the case manager wrote that he made a home visit to the client. There is no indication that the client was notified about the intended visit, and he was not home. The case manager left a message with the client's stepfather. The client came to the clinic, received medications and scheduled an appointment for the end of October. The record does not explain why the client was absent for almost four months.

The SCMHC record does, however, contain a letter from a SEH social worker dated September 14, stating that she was contacted by the client's conservator concerning the client's "deteriorating mentally." There is no record that SCMHC staff ever responded to this letter.

There is no record that the client came in for another four months, between early October and mid-February. No attempts to reach him were documented during these four months. In February, another home visit was attempted; again there is no indication that the client was notified, and again he was not in.

The above findings and case examples make it abundantly clear that without timely outreach -- still not performed at South Center -- many clients do not and will not receive the treatment they need.

D. Medical Needs

The July 1982 site visit found that the centers lacked sufficient medical staff to provide the medical care needed by clients. (Site-Visit Report, pp. 12-13.) Case managers could meet this need by assertively helping clients to obtain needed medical services elsewhere, the site-visit team stated, and by closely monitoring the provision of such services as required in the Dixon Plan (p. 145).

In March 1983, except for a few cases in which case managers were conducting well-documented medical follow-up, the surveyors found very little information about medical services beyond notes that a referral had been or would be made to a private doctor or clinic.

Generally, it may be assumed that clients will follow such

referrals and that, without indications to the contrary, their medical needs are being met. However, when it is obvious their medical needs are not being met, close monitoring is essential, followed by reassessment of and change in the treatment plan when the current interventions are not working.

Two case examples recorded by the March 1983 survey illustrate this need:

Case 64: This client was a 56-year-old client, admitted to SCMHC in April 1982. On his very first appointment, his case manager sent him home. The note for this day states: "He had a very bad body odor. Was sent home because he was so dirty. Was given a note to give to his landlady and she called. Stated she would ask him to take a bath before coming here for I.M. medications."

Two days later, when the client returned, the possibility of a medical problem was noted: "His appearance neat, but he smelled like feces ... stated he had been having diarrhea for two weeks. It was suggested that he stop in D.C. General Hospital (DCGH) Medical Clinic." Whether the client went to DCGH is not recorded.

A month later, the doctor noted: "Patient here for prolixin injection, but states he has pain in his stomach. I sent him to DCGH for emergency check-up." Whether the client went to DCGH is not recorded.

In May the case manager also learned the client had moved. A review of his SEH record showed that the client had been told to leave his foster home because his persistent coughing was bothering others. On his own, he found a room in a rooming house. There is no record that the case manager ever attempted to visit to see if his medical and other needs warranted a more supervised setting.

In June the client was observed "suffering from shortness of breath because of his chronic emphysema." He was accompanied by staff to the emergency room of DCGH, where he was admitted as an inpatient.

Approximately two weeks elapsed before his case manager tried to contact the client at the hospital. When the case manager arrived, she learned the client had already left.

In late July the case manager wrote a letter to the client (he has no phone at the rooming house), saying he "is late for medication." Although he had been hospitalized only a month earlier, no other attempts were made to reach the client. There is no indication that the client responded to the letter.

On August 20, the client returned to SCMHC. According to the progress note: "He is in acute distress. He has congestive heart failure, 4+ pitting edema chronic with evidence of anemia and pulmonary osteoarthopathy. BP was 100/80. ... He was unable to walk from the elevator and passed out. Transportation was sent to DCGH and patient was taken to emergency room," where he was admitted as an inpatient.

On September 16 the client died.

The medical information in the client's SEH record states that the client has "chronic obstructive pulmonary disease, traumatic vision loss in left eye and borderline elevated BUN." But the client's treatment plan at South Center, written in late April, was never revised. Under "Current Medical Problems," it states "none known."

Clearly, this client had serious chronic medical problems about which SCMHC staff were aware. Yet instead of revising his treatment plan to arrange for treatment by a private physician who could follow him closely and provide continuity of medical care, SCMHC staff repeatedly responded to his medical problems only by sending him to the DCGH emergency room.

Case 218: This client is a 72-year-old woman, admitted to SCMHC in July 1982. She has lived in the community relatively successfully with her husband since 1978. But she has had eight operations, and her last three admissions to SEH, between 1973 and 1978, were for medical problems.

In early November the case manager noted that the client had an appointment to see Dr. X (a private physician). But several days later, the case manager noted: "Patient did not see Dr. X, stated he charged \$75 which they did not have at the time. Staff will talk with husband and make another appointment to see Dr. X."

Over the next several months, the case manager stayed in close phone contact with the client and her husband because the client was periodically ill with "a bad cold." She kept telling the client to see Dr. X, even though the client had indicated that she could not afford Dr. X. In early February, the client was hospitalized with pneumonia. The plan for continued medical follow-along when she left the hospital was "to go see Dr. X."

In sum, this is a case where the plan for medical follow-along was clearly not working, apparently because the client could not afford the doctor. Yet this knowledge never led to a reassessment and revision of the treatment plan to meet the client's medical needs.

E. Provision of Case-Management Services

The site-visit team found a serious deficiency in case-management services provided by the District's CMHCs in July 1982. Clients' "progress notes rarely contained information about the type or duration of specific case-management services provided to the client." The site visit revealed that "the bulk of case-management time at both centers is currently spent in obtaining a brief status report from a client when he comes to the center for medication review and in making a general and brief report to the physician on 'how client is doing.'" (Site-Visit Report, p. 28.)

1. Amount of Case Management Provided

Of the 52 CMHC client records reviewed in March 1983, not one contained progress notes documenting the duration of any case-management service. It is impossible to tell, therefore, whether a

client was seen by a case manager for several minutes or several hours. Consequently, there is no accountability for the minimum of four hours per month of case management services to chronic clients required by the Dixon program standards. The types of case-management services that are recorded (primarily office visits and phone calls) and the infrequency of case managers' progress notes offer little evidence that four hours' worth of service was provided to most clients in any month.

2. Types of Services Provided

In the 34 records of clients whose case manager could be identified, the surveyors found that most case-management service continues to be in the form of office visits and telephone calls, usually surrounding a medication visit. Both the July 1982 site visit and the March 1983 survey found that case managers' progress notes are generally brief reports about medication and "how client is doing." While this is sufficient for some clients, others need much more (Site-Visit report, p. 28).

The March 1983 survey showed that 27 clients had such office visits; 14 received telephone calls. There was very little evidence that SCMHC offers other case-management services required by the Dixon program standards. The survey found only three cases in which insurance or public-benefit forms had been filled out by case managers; four cases of home visits by case managers; four referrals to another service provider (usually to a private physician, for medical needs) by case managers; and two referrals for vocational rehabilitation services and one meeting with vocational rehabilitation workers.

The March 1983 survey did not find a single instance of a case manager's accompanying a client to other service programs or visiting other service programs in which a client is involved; going with a client to a benefit office or assisting a client in filing an appeal in a case of terminated benefits; helping a client find housing; helping a client solve daily-living problems such as shopping, riding a bus or housekeeping; visiting a client at a job site or helping a client solve job-related problems such as wages and transportation; or helping a client learn to budget and manage money. In fact, five of the 34 records of clients with identifiable

case managers contained no case-management progress notes at all for a period of more than three months. Given the seriousness of these clients' illness, it is inconceivable that they do not need the case-management services called for in the Dixon Plan and program standards.

3. Delivery of Services

In July 1982, the site-visit team recognized that case management, as defined by the program standards, means in practical terms that "the clinician/case manager must often leave the physical confines of the treatment setting to perform helping services, such as teaching the client how to ride the bus to the clinic, going to the Social Security office to help the client get funds to support himself in the community, going with him to help him find a furnished room so he has a decent place to live, even providing assertive outreach outside the center when he is in periods of crisis." (Site-Visit Report, p. 25, emphasis added.)

Other than the visits to four clients' residences mentioned above, the March 1983 survey found virtually no indication that case managers ever leave the premises of South Center. Case managers continue trying to solve clients' daily-living problems from behind their desks and over their phones. For some problems of some clients, this works. However, both the July 1982 site visit and the March 1983 survey found that the current system breaks down when more is required, as the following example illustrates:

Case 43: This client is a 46-year-old woman with a diagnosis of chronic schizophrenia, transferred to South Center in January 1982. According to her SEH discharge summary, "Patient has been on convalescent leave for almost seven years and has made an excellent adjustment in community all these years. She attended our outpatient clinic and was seen every 7-8 weeks during the weekend in order not to interfere with her work in town."

SCMHC would not accommodate her need to be seen on weekends. Instead she was to come in on weekdays, even though she had to commute to her full-time job in Springfield, Virginia.

SCMHC staff first noticed in July 1982 that the client was showing signs of deterioration. "Patient appeared to have regressed a little. ... States medication not as strong as at SEH. Encouraged her to tell me when things not going well, including between visits."

In mid-September she was reported as being "withdrawn and losing weight. CRF sponsor can't get her to eat, also somewhat hostile. Will have patient come in on Friday." (Writer called CRF operator to remind her.)

Three days later: "Patient is regressing, getting withdrawn since she was placed on reduced Thorazine. Will put her back on 300 mg. Thorazine."^{2/}

Notes from mid-November on indicate the client began to miss appointments and have increased stress at her residence and her job. She reported to SCMHC staff that she had not come in for her appointments because "she got her medications from a former nurse at SEH."

The last entry at the time this record was reviewed is in early March, one month after SCMHC staff's last contact with the client. "Patient in this a.m. ... appears to be regressing and withdrawn. Will refer her to Dr. X. Unable to get appointment as she (Dr. X) was filled with appointments. Patient to be seen by Dr. Y who requested patient be seen by Dr. Z." The client was finally seen by Dr. Z, but the note is not legible. It is not possible to identify the responsible psychiatrist on this client's treatment team.

Despite ample documentation that this client was regressing, becoming withdrawn, losing weight, experiencing stress on her job, getting her medications from another source and having problems at her residence, her individual treatment plan, written in February 1983, states: "Patient needs limited case management as she has a consistent pattern in life -- works five days, does chores on Saturday; Sunday attends Church...."

In sum, case management as required by the Dixon program standards, not found at SCMHC by the site-visit team in July 1982, still does not exist as of March 1983.

III. CRISIS RESOLUTION

Of the 52 survey clients, 10 (19%) have been rehospitalized -- three of them two or more times after being transferred to the District's responsibility. Two of these clients were hospitalized primarily for medical problems; eight for psychiatric reasons.

These hospitalizations occurred from one to 11 months after the clients were transferred to the District's responsibility. The clients were all outpatients at the time of transfer; they had been living in the community and had achieved some degree of stability prior to transfer. Three had lived in the community from five months to a year; one had lived in the community longer than one year; and six had been in the community for more than two years -- three for more than four years.

2/ The change in medication is significant. The information in the Client's SEH file shows she was being maintained on 900 mg. of Thorazine a day. When she came to South Center in January, they dropped her medication to only 255 mg. a day. No explanation is given as to why this was done. In September, they finally decided to increase it to 900 mg. a day, but by February they decreased it again (no explanation given) to 225 mg. a day. It should not be surprising that she decompensated; her medication had been cut by about three-fourths.

The July 1982 site-visit team reported that hospitalization -- extrusion from the community -- is "one of the most disruptive events in a mentally disabled person's life." (Site-Visit Report, p.33.) The Dixon program standards for crisis intervention/resolution were designed specifically to prevent hospitalizations.

The goal of crisis intervention is the restoration as promptly as possible of the equilibrium which existed prior to the acute emotional crisis experienced by the patient/client (together with its physical and social concomitants).

Associated with this goal are three objectives:

- the immediate reduction of acute emotional distress and its physical and social manifestations, and
- assurance of the safety of the patient/client and of others.
- minimal disruption to the patient/client by resolution of the crisis in the least restrictive setting appropriate to the nature of the crisis.

As the site-visit team noted in its August 1982 report, these standards require the following four functions:

- identification of the nature of the crisis and the personal situational circumstances that have contributed as proximate casual factors;
- immediate action to facilitate stabilization either by provision of direct services or referral of the patient/client to another site where direct service is promptly available (referrals should often be accompanied by direct assistance in making contact with the intended provider);
- immediate identification and direct involvement of the treatment staff who have the most knowledge about and familiarity with the patient/client; and
- commitment to assess and attempt to resolve the crisis in the least restrictive setting appropriate to the nature of the crisis, first, by resolving the crisis in the setting where it occurs whenever possible; second, by arranging placement of the patient/client in a temporary residential crisis facility if appropriate; and third, by hospitalizing the client, as the last resort. (Site-Visit Report, pp. 15-16.)

Although the site-visit team applied the above standards primarily to its July 1982 review of the Crisis Resolution Unit (CRU), the Dixon program standards apply equally to any CMHC staff handling clients' life crises. Accordingly, when CMHC staff assume respon-

sibility for providing crisis resolution services themselves instead of referring a client to the CRU, they must adhere to the appropriate standards.

In July 1982, the site visit found that the "CRU is not a crisis-resolution unit as required by these standards. It is instead primarily a 'traffic-directing' unit, or one that does one-time evaluations and then directs the crisis to another resource." (Site-Visit Report, p. 16.) Supporting this conclusion, the site-visit team cited six major deficiencies in client care. These are compared below with the deficiencies the surveyors found in crisis resolution at SCMHC in March 1983.

1. Face-to-Face Outreach

Face-to-face outreach -- going to where a client is when he is unable or unwilling to come to the center -- is a clinical necessity. It is required to assess the immediate situation and to take steps necessary for stabilizing the client and preventing further decompensation and hospitalization. In July 1982, the site-visit team found that such outreach rarely occurred. (Site-Visit Report, pp. 19 and 35.)

The surveyors found in March 1983 that from the time a client was first known to be in crisis or was first observed by SCMHC staff as showing signs of regression and/or had started missing needed treatments, actual outreach -- going to the client -- was not attempted once for any of the 10 clients subsequently hospitalized.

2. Telephone Outreach

The site-visit team found in July 1982 that phone calls were the primary method of reaching clients, and that when clients did not respond to phone calls, little else was done.

The March 1983 survey found that a month or more had gone by before telephone outreach was attempted to four of the five clients who were hospitalized after missing scheduled treatments at SCMHC. With timely and appropriate outreach, the hospitalizations might well have been averted.

3. Least Restrictive Alternative

In July 1982, the site-visit team found that virtually no efforts were made to avert hospitalization by resolving a crisis in a

less restrictive setting as required by the Dixon program standards for crisis resolution. For example, no client referrals had been made to a temporary-crisis residential setting as an alternative to hospitalization, even though such a program was under contract to MHSA. (Site-Visit Report, p. 18.)

The March 1983 survey found that SCMHC staff had not referred a single client to a temporary-crisis residential setting as an alternative to hospitalization. As a result, the cycle of continual rehospitalization interspersed with periods of community living is never broken -- the "revolving door" never stops turning for these clients.

Two case examples illustrate SCMHC's failure to use the least restrictive alternative in crisis resolution:

Case 41: After being admitted to SCMHC, this 26-year-old client with a primary diagnosis of schizophrenia was hospitalized at St. Elizabeths for three weeks. When he returned to SCMHC, he had no place to live. For several nights he had stayed with his brother, who had gotten drunk and beaten him up. Instead of attempting to locate a suitable temporary residential arrangement for the client until he could be stabilized, SCMHC staff asked SEH to rehospitalize the client "until a stable living condition can be worked out." SEH would not admit him for this reason.

Case 61: This client is 70-year-old woman with a diagnosis of schizophrenia, who had been living in the community with her sister for more than a year. Her sister died suddenly. The family called SCMHC to "see whether we could be of assistance to her in placing patient temporarily until funeral arrangements can be made." Instead of calling the temporary-crisis residential program under contract to MHSA, SCMHC referred her to the CRU. Her SCMHC records do not indicate whether the CRU tried to place the client in a temporary-crisis residential setting. The CRU did have her admitted immediately to St. Elizabeths. Seven months later she is still there, awaiting placement in a suitable CRF.

4. Coordination

The site-visit team found in July 1982 that when CMHC clients are seen by the CRU, the CMHC is not informed of the outcome of the intervention. (Site-Visit Report, p. 32.)

The March 1983 survey found that of its clients who were rehospitalized for psychiatric reasons, both of those who were referred to the CRU were hospitalized immediately by the CRU. A progress note shows that SCMHC staff are aware of this outcome. But these clients' SCMHC files contain no reports from the CRU indicating what assessments were conducted, what less restrictive alternatives were considered or tried and what interventions were offered

to avert hospitalization -- all information the client's treatment team needs to help prevent and resolve future crises.

5. Interventions

The July 1982 site visit found crisis-resolution services to consist primarily of one-time evaluations and referrals. The site-visit team labeled such services "traffic directing" because they do not resolve the client's crisis but simply direct it elsewhere -- ultimately to the hospital. (Site-Visit Report, pp. 16 and 23.)

The March 1983 survey found that even when SCMHC staff documented that the client was decompensating, there was an overall lack of intervention designed to reverse the process by assessing what was causing the regression and instituting appropriate treatments. The one notable exception was medication. SCMHC staff frequently responded to a developing crisis by increasing or changing a client's medication. While this is often necessary and can sometimes be sufficient, many clients require other interventions as well.

Two case examples illustrate:

Case 143: This client is a 57-year-old man with a primary diagnosis of psychosis and a secondary diagnosis of mild mental retardation. He had lived in the community with his parents since being outplaced from SEH in 1975, followed by the hospital's outpatient clinic. In April 1982 he was transferred to SCMHC. He was seen at monthly intervals by SCMHC staff. In early November 1982 he began to show signs of regression. A progress note states, "Patient has problem sleeping at night. His medication (Thorazine) was increased until his next appointment."

Three weeks later SCMHC staff observed that the client was "depressed, withdrawn," and his medication was changed to Prolixin. One week thereafter, SCMHC staff suggested to the client's brother that the client be rehospitalized at SEH. The brother refused. SCMHC staff then suggested Capitol Hill Hospital near the mother's home. He was admitted there. After living in the community for almost eight years, he was rehospitalized less than nine months after being transferred to the District's responsibility. The SCMHC staff recorded his progressive deterioration, but offered no concrete interventions beyond medication changes.

Case 257: This client is a 44-year-old woman with a primary diagnosis of schizophrenia. She lived with her daughter in the community for two years while being followed by SEH's outpatient clinic. Her history showed that she started to deteriorate when she was confronted by family problems she could not handle and when she stopped taking medication. The client was transferred to SCMHC in June 1982.

In early July the SCMHC observed that the client refused to attend the program, except for medication. The CMHC's plan: "Will slowly attempt to involve client in a day activity program and/or nutritional program." The client had one appointment in August. In early September,

SCMHC staff reported that she came in for medication and is "willing to attend (day treatment) once a week."

The next progress note, one week later, states: "Client was admitted to St. Elizabeths through crisis resolution unit this a.m. This case will remain open." Her SCMHC record includes no record of any assessments or interventions made by the CRU other than the ultimate decision to hospitalize her.

The client remained at St. Elizabeths about three weeks. The note on her return to South Center states: "Patient has been out at St. E's. She says nothing was bothering her. ... She is resistant to coming in for day treatment ... her medication was increased. Will encourage patient to come in for treatment."

The client continued coming to SCMHC for medication and physical exams until the first week in November. In early December, SCMHC staff called her, noting in her record: "Patient hasn't been in due to financial problems, but promises to attend on Thursday."

Almost two months later, CMHC staff called the client again. She returned to treatment and the SCMHC staff observed further deterioration: "Client came in today, appears depressed, withdrawn and refuses to talk." A telephone call was made to the client's sister, "who stated, 'Patient needs to be involved in the program.' ... Hopefully, patient's sister will encourage patient to attend this program." Another note states: "Patient promises to attend this program three days a week, starting Monday morning. Without this program patient appears to deteriorate."

A note recorded CMHC staff plans to meet to assess whether a home visit is warranted. The record documents calls in each of the next two weeks to the client's sister, who reported the client "is deteriorating; she isn't consuming appropriate intake; is sustaining injuries through falls in the home."

A case review was scheduled at this stage; there is no record of it in the file.

The next note, written after two more weeks, states: "Patient was brought in by the police and she was 'ranting and raving' -- screaming that the police were going to kill her. She is now mostly mute. Will arrange for her to be admitted to SEH."

The woman was admitted to SEH on March 3. A psychological and social/cultural assessment of the patient performed at the hospital found: "Patient is almost totally mute and catatonic ... she was in a much more decompensated state than she was upon her last admission." The client is still at St. Elizabeths.

Although SCMHC staff knew the client had missed appointments that were necessary to keep her from deteriorating, their only attempts to reach her were phone calls made weeks after she had stopped coming. No home visits were documented. Her treatment plan was never re-evaluated, or if it was, the re-evaluation was not recorded. In sum, after living in the community for two years the client has now been rehospitalized not once but twice in a period of less than nine months after being transferred to the District's responsibility.

6. Evaluation and Assessment

In addition to the actions required by the Dixon program stan-

dards for crisis resolution to avert hospitalization, the site-visit team also noted in its August 1982 report that once hospitalization does occur, another series of assessment actions is required. "Whenever a patient/client is hospitalized for psychiatric reasons," the Dixon program standards for evaluation and assessment mandate that "an evaluation/assessment will be performed to document precipitating cause(s) for the hospitalization; the nature and duration of the crisis assistance offered (if any); the attempt made to resolve the crisis in the least restrictive setting; the name(s) of the person(s) and place involved in the crisis resolution; and the plan to maintain contact with the patient/client and assist him or her to return to the community as quickly as possible." (Program Standards, Section C-2.)

In July 1982, the site-visit team found little evidence of the centers' compliance with these standards when a client is hospitalized. (Site-Visit Report, p. 32.)

The March 1983 survey found no more evidence of such compliance. In only one of the files of the eight clients who were re-hospitalized for psychiatric problems was any of the following documentation required by the program standards found:

- Evidence that an evaluation/assessment had been performed to document and evaluate the nature and duration of crisis assistance offered (if any);
- Evidence that an evaluation/assessment had been performed to document and evaluate the attempts made to resolve the crisis in the least restrictive alternative;
- Evidence that an evaluation/assessment had been performed to develop a plan to maintain contact with the client and assist him to return to the community as quickly as possible; and
- Evidence that an evaluation/assessment had been performed to review and if necessary, modify the treatment plan to avert future hospitalizations.

7. Related Actions by Case Managers

The program standards for case management require the case manager to take a series of actions when a client is hospitalized or placed in a temporary crisis residential setting. The case manager "should maintain contact with the patient/client while in that setting, work closely with that staff, and assist the patient/client to

maintain community ties (e.g., keeping slot open in a residential or vocational program) in order to facilitate the patient's/ client's return to the community." (Program Standards, Section C-2.)

In July 1982, the site-visit team found little evidence that these steps were being taken by center case managers when a client was hospitalized. (Site-Visit Report, pp. 28, 32.)

The March 1983 survey found virtually no evidence of these steps. In none of the files of the eight clients hospitalized for psychiatric problems was there any indication that the case manager had maintained contact by phone, by letter or in person with the client while he was hospitalized. Only one file had a record of any contact by any CMHC staff member with hospital staff. In that case, the contact was broken off a week later, even though the client remained hospitalized for another seven months. Further, there was no record in any file that SCMHC staff, failing to receive information from the hospital automatically, had sought information from hospital staff about the client's response to hospitalization, his treatment while hospitalized, his discharge plan, his need for different or more intense services upon return to the community or even the date when he might be expected to return to SCMHC.

The above findings and case examples clearly demonstrate the continued existence of the major deficiencies the July 1982 site visit found in crisis intervention and other services designed to stabilize a client, prevent deterioration and avert hospitalization. One of the most disruptive events in a mentally disabled person's life -- hospitalization -- continues "for all practical purposes [to] be a non event to the very system that could help avert it." (Site-Visit Report, p. 33.)

CONCLUSIONS

Its July 1982 evaluation of the District's Community Mental Health Centers led the site-visit team to reach three major conclusions about client care:

- (1) Fragmentation of services and the lack of accountability on both a systemic and an individual level impede continuity of care and often lead to hospitalization or to clients' disappearance from the mental health care system.

(2) The centers have not designed their services to meet the needs of chronic severely disabled clients, as the Dixon Plan requires and, consequently, the clients are in jeopardy of repeated instability, crisis and hospitalization.

(3) The lack of adequate resources at the centers precludes the delivery of essential services to severely disabled clients living in the community and encourages their rehospitalization.

The site-visit team provided detailed evidence to support these three findings with regard to continuity of care, case management and crisis resolution services. At the end of their report, the site-visit team concluded:

It is the unanimous opinion of this site-visit team that the existing community mental health system is seriously deficient in its ability to meet the needs of a large number of Dixon class members." (Site-Visit Report, p. 43.)

The recent monitoring project of 100 clients who have been discharged from St. Elizabeths' outpatient rolls to the District's community mental health centers is only half completed, but its sample size of 52 cases at South Center is a sufficient basis on which to draw meaningful conclusions. This survey was undertaken to discover what has happened to Dixon class members who were transferred to the District's responsibility pursuant to the Consent Order and Plan.

A number of the clients who have been transferred appear relatively stable. They are willing and able to accept the treatments offered to them at the centers and require only minimal therapeutic interventions. For these clients, both the July 1982 site visit and the March 1983 monitoring project found, the system appears to work reasonably well. However, as the site-visit team found last July and the March 1983 survey now confirms, the system breaks down when the client requires more. The findings and case examples in this report clearly document the results of this breakdown -- significant numbers of transferred clients failing to receive needed services for months at a time, being rehospitalized or being terminated from the center's rolls. Furthermore, the same major deficiencies in continuity of care, case management and crisis resolution that were identified during the July 1982 site visit were found during the March 1983 survey.

In December 1982, the District acknowledged to the court, in greater or lesser degree, the deficiencies found by the site-visit team. The Mental Health Services Administration stated that it had already corrected or was in the final stage of correcting many of them. The District may indeed have engaged in extensive administrative activities involving staffing, training, computerized data collection and revision of forms, but the March 1983 survey clearly demonstrates that these activities have not significantly improved services to Dixon clients. Clients who need intensive case management, aggressive outreach, timely crisis resolution and monitoring and follow-through of their treatment plans are being harmed and will continue to be harmed until the services required by the Dixon Plan and program standards become available.

The survey's 1983 findings, unfortunately, come as no surprise to the Dixon Implementation Monitoring Committee. As the committee stated in its September 30, 1982, recommendations to the court, the Mental Health Services Administration has repeatedly demonstrated that it is not capable of solving these problems.

The findings of our most recent survey simply underscore what was already clear: that the District defendants cannot bring about the necessary changes in client care required by the Dixon Consent Order and Plan and that a special master is urgently needed.

Submitted by:

Leonard I. Stein, MD
Gail Marker, MSW
Susan Bergeron
Chainie Scott
Harry Schwarz

Edited by:

Lee A. Carty

April 5, 1983

RESULTS OF CUTS OF THE HOSPITAL BUDGET

Senator SPECTER. What is your conclusion, Mr. Rosenberg, as to the proposal by Dr. Mayer on the situation that you have outlined in the litigation?

Mr. ROSENBERG. Our conclusion is that we believe that the precipitous and dramatic cuts of the hospital budget at this point will result in very, very serious problems to patients within the hospital and potentially will have serious impact on the District of Columbia's ability to absorb patients who may be released as a result of RIF's and other changes in the hospital's budget.

It would be very difficult for the District of Columbia to absorb those patients now and to provide effective mental health care in the community.

Senator SPECTER. What order have you received from the court as a result of your instituting this litigation?

Mr. ROSENBERG. The decree in this lawsuit requires that all patients who do not need 24-hour hospitalization and fall within specific diagnostic categories, that those persons have a right to placement in the community and the District of Columbia has an obligation to develop services and programs to meet their needs.

Senator SPECTER. Have those programs and services been developed to meet the need of all of these people?

Mr. ROSENBERG. They have not. But I should say that we believe that good progress is on the horizon. This lawsuit has been pending since 1975. In 1980 the District and the Federal Government negotiated an agreement for the development of services to meet the needs of these patients. Now, that process has not moved along very well and as I said, we were forced to return to court last summer asking that the District be cited for contempt of court and asking that a special master be appointed to oversee implementation; that is, to oversee the District's process of developing needed services and programs.

PREPARED STATEMENT

Senator SPECTER. I think we have your point. We have your testimony and we have received the documents you have submitted.

Thank you very much.

[The statement follows:]

STATEMENT OF NORMAN S. ROSENBERG

Mr. Chairman, members of the subcommittee. I appreciate the opportunity to appear before you today. My name is Norman S. Rosenberg. I am the director of the Mental Health Law Project, a Washington, D.C. based public interest organization which, for more than a decade, has worked to improve the quality and availability of services for mentally ill and mentally retarded people, in institutions and in the community.

I am here today in my capacity as counsel to the plaintiffs in *Dixon v. Heckler and Barry*. This is a Federal court lawsuit brought in 1974 with the goal of ending the unnecessary confinement of many of St. Elizabeths Hospital's patients and compelling the establishment of suitable programs and services for them in the District of Columbia.

In 1975 Federal District Judge Aubrey Robinson issued a landmark opinion in the *Dixon* case. In it, he ordered the District and Federal governments jointly to plan for and create a continuum of services for current St. Elizabeths patients and those at risk of future hospitalization.

Not surprisingly, it has been exceedingly difficult to shift the locus of care from the hospital to the community and develop this continuum of services which was envisioned by the court. The obstacles to this process are exacerbated by the existence of two mental health systems in the District of Columbia—often serving the same clients but separately administered. St. Elizabeths Hospital is operated by the Federal Government and the community mental health centers are operated by the District's Mental Health Services Administration.

It would be less than candid to say that our goal of creating an integrated mental health system has been entirely successful. It has not. In fact, counsel for the *Dixon* plaintiffs have had to return to court several times, most recently requesting that the District's government be held in contempt and that a special master be appointed to oversee compliance with the court's mandate in *Dixon*.

However, despite the serious and continuing problems, progress is now being made in negotiating with the District. For this reason we have asked the court to defer ruling on the outstanding motions. But we are concerned that the progress resulting from these negotiations may be negated by significant cuts in the hospital budget or by cuts the District might make if it had to transfer large additional sums to the hospital. We fear that the mentally ill people of the District of Columbia will be the victims of these cuts.

The budgets of the hospital and the D.C. Department of Human Services for mental health services are inextricably linked through congressional decisions on appropriations. While we can understand the Federal Government's desire that local governments solve local problems, a precipitous and dramatic reduction in Federal dollars to the hospital will undermine the District of Columbia's efforts to improve its mental health care system. For the past 2 years, the D.C. budget and the St. Elizabeths budget have not been in sync. The District proposed payment of \$24.7 million in fiscal years 1983 and 1984, while the St. Elizabeths budget assumed receipt of \$35.6 million in fiscal year 1983 and \$54.5 million in 1984. Last year, Congress appropriated sufficient Federal funds to the hospital to bridge the gap. In fiscal year 1984, however, we understand the House Labor-HHS Subcommittee has not added funds to the Federal appropriation to make up the \$29.8 million difference between the amount included in the D.C. appropriation and the payment expected by St. Elizabeths.

This disparity should not be permitted. It will lead inevitably to the deterioration of patient care, the elimination of demonstration and support programs and other crucial services.

Mr. Chairman, you are in the difficult position of being a man in the middle. As chairman of both the D.C. Appropriations Subcommittee and member of the Labor-HHS Subcommittee, you are well positioned to reconcile these budgets.

We respectfully make the following suggestions:

1. Add funds to the D.C. appropriation, specifically earmarked for community mental health care. While this step would not ease the hospital's burden of absorbing the fiscal year 1984 cut, it would likely facilitate the shift of patient care from the hospital to the community.

2. Add funds to the St. Elizabeths appropriation, earmarked either for transfer to the District to create needed community services or to enable St. Elizabeths to contract with private providers for the purchase of mental health services. This proposal envisions a phased reduction, with the District assuming increased fiscal responsibilities in the years ahead.

3. We have consistently maintained that the total funds available to the two systems are sufficient to provide adequate mental health care to D.C. residents. But there is an imbalance between funds allocated for inpatient services as compared with community care. Our aim is to shift funds into community care. And that is the basis for advancing recommendations 1 and 2. However, if funds cannot be added for community care because of the status of the D.C. appropriation bill or for other reasons, we believe that the funds needed by the hospital must be provided either by raising the D.C. payment or making up the shortfall through a higher Federal payment.

We offer the third option somewhat reluctantly. However, in the interests of mentally ill people in the District, we cannot subscribe to a policy which, by default, will result in a 16- to 20-percent reduction in hospital personnel over a 3-month period. Such reduction could cause havoc on the wards, in the clinics, and in the outplacement process. These cuts will inevitably affect the wrong people at the worst time.

STATEMENT OF CLARENCE MARTIN

Senator SPECTER. The next witness is John Connelly.

Then we will turn to Mr. Martin, Clarence Martin of the Association for the Advancement of Psychology.

Mr. MARTIN. Thank you.

My name is Clarence Martin. I am executive director and general counsel for the Association for the Advancement of Psychology, and I appear here today on behalf of the 72,000 members of the American Psychological Association and the AAP.

I ask that my testimony be entered into the record as read.

Senator SPECTER. Do we have your testimony?

Mr. MARTIN. Yes, you have it.

PREPARED STATEMENT

Senator SPECTER. It shall be made a part of the record. We would appreciate it if you would summarize it.

[The statement follows:]

STATEMENT OF CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL,
ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

My name is Clarence J. Martin. I am Executive Director and General Counsel of the Association for the Advancement of Psychology (AAP), and I appear here today on behalf of the 72,000 members of the American Psychological Association (APA) and the AAP.

I hesitated to appear here today because I am not armed with facts and figures that usually qualify an association such as ours to present public testimony, but my hesitation has been overcome by a genuine sense of indignation that the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) would hold countless mental health patients and 635 federal employees hostage to their negotiations with the District of Columbia government over a difference of opinion in budget responsibility.

Unique programs are being put in jeopardy as a negotiating ploy to push the District of Columbia into assuming additional jurisdiction over and financial responsibility for St. Elizabeth's Hospital.

The nation's foremost model bilingual outpatient services has been singled out for elimination. This despite that both the House and Senate appropriations committees have for several consecutive years identified minority programs as a priority area for ADAMHA expenditures in both research and clinical training.

Another program specifically identified for elimination in the July 22 memo is the Mental Health Program for the Deaf (MHPD). This is a unique program unduplicated anywhere in the world. Abandonment of this program constitutes a callous disassociation from one of the most underserved populations in this country.

The Child and Adolescent program presently conducted at St. Elizabeth's provides services which are not otherwise provided in this area. The officials at ADAMHA may argue that these services should be provided by the District of Columbia, or Virginia or Maryland or some tri-state commission. That is not the issue.

Even if ADAMHA is right, an orderly transition of the funding authority of

the Child and Adolescent program should be negotiated. If this program is closed down on October 1, 1983 without provisions for a substitute program; if the District of Columbia has to start over from scratch on October 1st with no provisions for utilizing the personnel and the experience of the ongoing programs it will not save money. Not only do the regeneration of such programs prove more expensive but the interruption in service will be even more costly to the community.

We are deeply concerned about the individuals who are served by these programs--hispanics, the deaf, and children and adolescents--unserved and underserved populations upon whom the burden of limiting spending is being placed.

The other victims of these exploitive tactics are the employees of St. Elizabeth's. Mr. Chairman we have the best civil service in the world and it's time we started treating them like the best.

Using civil servants as pawns in a budget negotiation is insensitive at the best and self-destructive at the worst. The relations between the employees at St. Elizabeth's and ADAMHA have been tense for some time. This latest affront only works to deteriorate that relationship.

There may be a need to reduce the work force at St. Elizabeth's but going about it this way is simply poor management and is condemnable for that reason alone.

We are not privy to the state of negotiations presently taking place between ADAMHA and the D.C. government concerning the status of St. Elizabeth's but earlier this year we testified before the Appropriations Subcommittee on Labor, Health and Human Resources on this issue and I would like to reiterate some of the things we said then.

I ask that a copy of that statement be introduced in the record at this point.

In summary, Mr. Chairman, though we appreciate ADAMHA's concern that St. Elizabeth's be financially self-sufficient we believe the first priority should

be the welfare of the patients and maintenance of priority programs which provide assistance to unserved and underserved populations.

We are also concerned that the work force not be exploited by ADAMHA for political reasons. We are concerned about the frequent rumors in the press that St. Elizabeth's, which Dr. Mayer himself describes as a "precious national resource", is being dismembered to provide access to the grounds for real estate development.

I hope that these hearings will help provide some answers to these concerns. The Chairman should be congratulated on responding to these problems in such a timely way. I assure him that the american psychological community is aware of and appreciative of his continuing sensitivity to mental health needs.

ST. ELIZABETH'S HOSPITAL

The emphasis of the administration's testimony continues to be the "financial self-sufficiency" of St. Elizabeth's Hospital. We appreciate the administration's announcement that "considerable progress has been made in the area of patient care financing." We are concerned that the real issues should be first of all the quality of care for patients in St. Elizabeth's. Secondly, we believe a determination of the status of St. Elizabeth's, which ADAMHA Administrator Mayer describes as a "precious national resource", as a national institution needs to be made.

Again this year the administration has proposed to unveil at some uncertain future date a public, or quasi-public, corporate structure to govern and manage St. Elizabeth's. These vague proposals are presented at the same time that we see newspaper articles suggesting that the treatment facilities may be moved to another site and that the present location may be sold to private investors as a choice real estate development.

St. Elizabeth's is a unique, historically significant institution serving the District of Columbia, Maryland and Virginia and especially providing services in the highly underserved area of Anacostia. It is staffed by exceptional and azygos personnel in both its clinical and research activities. It does not seem unreasonable that such an

institution should receive federal subsidization and protection from commercial intrusion equal to that of any other significant monument in this capitol city and that its staff should not suffer annual threats of being shifted from one governmental authority to another.

We support the proposed budget of \$143.5 million for FY 1984.

The increase of the District of Columbia's share of the FY'84 program budget is totally unreasonable. \$3.3 million is being charged to the D.C. government for start-up costs for the proposed corporation. This is simply not the financial responsibility of D.C.

\$9.0 million is being charged for increased participation in inpatient costs at the same time the administration states in the testimony before this committee on April 14, 1983 that it has shown;

- 1.) An 11 percent reduction in the rate of rehospitalization for outpatients;
- 2.) An 8 percent decrease in admissions of patients screened by the intake unit;
- 3.) A reduction in the average length of stay from 16 days to 11 days;
- 4.) A drop in the inpatient census by approximately 6 percent since last year.

A \$15.4 million increase is being charged for care delivered District residents who do not require acute psychiatric care but require nursing care. This is clearly a federal obligation until such time as the management of St. Elizabeth's, or at least the nursing facility, is clearly transferred to the District of Columbia.

We urge this committee to appropriate the full \$143.5 million to St. Elizabeth's; to maintain the District of Columbia's contribution at \$38.8 million, rejecting the additional \$29.9 million increase; to once again urge the administration to assume full and active responsibility for the hospital, its staff and the quality of care of its patients until a definitive agreement can be negotiated on the future of this "precious national resource."

PROGRAMS MARKED FOR ELIMINATION

Mr. MARTIN. I hesitated to appear here today because I am not armed with the facts and figures that usually qualify an association such as ours to present public testimony. But my hesitation has been overcome by a genuine sense of indignation that the Alcohol, Drug Abuse, and Mental Health Administration would hold countless mental health patients and 653 employees hostage to their negotiations with the District of Columbia government over a difference of opinion in budget responsibility.

This is exactly what the Jackson memorandum of July 22 does. I have heard no reference to this memorandum earlier today. I presume the committee has a copy of that memorandum. If not, I will be glad to make one available for the committee's records.

Senator SPECTER. The committee does have a copy. I think the conclusions were referred to, although the specific name has not been referred to.

Mr. MARTIN. Thank you, Mr. Chairman.

Unique programs are being put in jeopardy as a negotiating ploy to push the District of Columbia into assuming additional jurisdiction over and financial responsibility for St. Elizabeths.

The Nation's foremost model bilingual outpatient services has been singled out for elimination. This, despite that both the House and Senate Appropriations Committees have for several consecutive years identified minority programs as a priority area for ADAMHA expenditures in both research and clinical training.

Another program specifically identified for elimination in the July 22 memo is the mental health program for the deaf. This is a unique program unduplicated anywhere in the world. Abandonment of this program constitutes a calloused disassociation from one of the most underserved populations in this country.

The child and adolescent program presently conducted at St. Elizabeths provides services which are not otherwise provided in this area. The officials at ADAMHA will argue that these services should be provided by the District of Columbia or Virginia or Maryland or some tristate commission. That is not the issue.

Even if ADAMHA is right, an orderly transition of the funding authority of the child and adolescent program should be negotiated. If this program is closed down on October 1, 1983, without provisions for a substitute program, if the District has to start over from scratch on October 1 with no provisions for utilizing the personnel and the experience of the ongoing programs, it will not save money. Not only do the regeneration of such programs prove more expensive, but the interruption in service will be even more costly to the community.

I know the chairman wants me to make this brief. I shall.

I will be happy to answer any questions that the chairman may have.

ALTERNATIVE FACILITIES GROSSLY INADEQUATE

Senator SPECTER. Well, the one question on my mind, Mr. Martin, is what facilities are available in the community to absorb the patients should the program be put into operation and what is your judgment on that?

Mr. MARTIN. Mr. Chairman, the facilities are grossly inadequate in this area. St. Elizabeths is not just a psychiatric hospital. St. Elizabeths serves a very, very broad purpose. It has to serve a broad purpose. There are an estimated 8,000 street people in the District of Columbia right now. Seventy percent of them have some kind of treatable mental illness. Some 10 to 15 percent of admissions to St. Elizabeths are non-residential. They are people who are drawn here seeking this jurisdiction to air problems which they have or imagine they have, and they wind up in St. Elizabeths. There are 15,000 heroin users and 50,000 alcoholics in the District of Columbia. And there simply are not adequate programs.

Do you know that at St. Elizabeths, for example, in the resident nursing program there are several people in there over 100 years old? Some have been there since the 1930's.

The District of Columbia may very well have inherited them, but I think closing down the nursing facilities without making provision that these kind of people can be taken care of would be inhumane and inconsiderate.

There simply are not the resources in the District of Columbia to substitute for what is being provided at St. Elizabeths, certainly not before October 1.

Senator SPECTER. Thank you, Mr. Martin. Thank you very much for coming.

And thank you, ladies and gentlemen, for being here.

The subcommittee will consider the matter. We are assured to some extent by Dr. Mayer's statement that the administration "has no intention of hurting patients or dumping responsibility for St. Elizabeths Hospital on the District of Columbia."

In light of a possible RIF of some 653 employees, which would be about 16 percent, there is an obvious question which is raised as to whether the objectives outlined by Dr. Mayer on behalf of the administration can be attained, that is whether there can be no dumping of responsibility on the District of Columbia and not hurting the patients. And this is something which we will have to take into consideration as to what will happen specifically to the people that will be affected by this kind of reduction in services. These are open questions we will explore further.

SUBCOMMITTEE RECESS

Thank you all very much. The hearing is adjourned.

[Whereupon, at 12:12 p.m., Tuesday, August 2, the subcommittee was recessed, to reconvene at 9:33 a.m., Tuesday, September 27.]

MATERIAL SUBMITTED SUBSEQUENT TO THE HEARING

[CLERK'S NOTE.—The following statements were not presented at the hearing but were subsequently submitted to the committee:]

(201)

STATEMENT OF YETTA W. GALIBER, EXECUTIVE DIRECTOR, INFORMATION CENTER FOR
HANDICAPPED INDIVIDUALS, INC.

MY NAME IS YETTA W. GALIBER. I AM THE EXECUTIVE DIRECTOR OF THE INFORMATION CENTER FOR HANDICAPPED INDIVIDUALS, INC. THE INFORMATION CENTER WAS ESTABLISHED IN 1969 AND HAS SERVED AS AN ADVOCACY ORGANIZATION FOR MENTALLY AND PHYSICALLY HANDICAPPED CHILDREN AND ADULTS IN THE DISTRICT OF COLUMBIA SINCE THAT TIME. THE CENTER ALSO SERVES AS THE PROTECTION AND ADVOCACY ("P&A") SYSTEM FOR THE DISTRICT OF COLUMBIA'S DEVELOPMENTALLY DISABLED CITIZENS UNDER AUTHORITY OF THE FEDERAL DEVELOPMENTAL DISABILITIES ACT, WHICH ACT MANDATES THAT EACH STATE (AND THE DISTRICT OF COLUMBIA) HAVE IN EXISTENCE A "P&A" SYSTEM TO INSURE THE PROTECTION OF THE LEGAL AND OTHER RIGHTS OF DEVELOPMENTALLY DISABLED PERSONS.

IN ADDITION, THE INFORMATION CENTER SERVES, UNDER CONTRACT WITH THE DISTRICT OF COLUMBIA, TO PROVIDE BOTH ADVOCACY AND COMPANION SERVICES TO INDIVIDUALS BEING DEINSTITUTIONALIZED FROM ST. ELIZABETH'S HOSPITAL UNDER THE MANDATE OF THE DIXON DECREE. ONE PROJECT, THE PATIENT ADVOCACY PROJECT, PROVIDES ADVOCACY SERVICES TO DEINSTITUTIONALIZED CLIENTS AT EACH OF THE DISTRICT'S TWO COMMUNITY MENTAL HEALTH CENTERS. THE OTHER PROJECT, THE VOLUNTEER ADVOCACY PROJECT, MATCHES VOLUNTEERS TO DEINSTITUTIONALIZED CLIENTS IN AN EFFORT TO EASE THE TRANSITION FROM INSTITUTIONAL TO COMMUNITY LIVING.

MY PURPOSE IN SUBMITTING TESTIMONY TO YOU TODAY IS TO ADD MY VOICE AND THAT OF MY ORGANIZATION TO THOSE OF OTHERS WHO ARE CONCERNED WITH THE RECENT "COST-CUTTING" MEASURES THE REAGAN ADMINISTRATION HAS PROPOSED FOR ST. ELIZABETH'S HOSPITAL.

THERE ARE FOUR POINTS I WOULD URGE YOU AND YOUR COMMITTEE TO CONSIDER.

1. THE PROPOSED BUDGETS CUTS WILL ADVERSELY AFFECT THE DISTRICT'S MENTALLY ILL POPULATION.
2. ST. ELIZABETH'S HOSPITAL HAS UNIQUE, VITAL MENTAL HEALTH PROGRAMS THAT NEED TO BE PRESERVED.
3. THERE IS NO EFFECTIVE TRANSITIONAL PLAN ENCOURAGING THE DISTRICT OF COLUMBIA TO ASSUME RESPONSIBILITY FOR ST. ELIZABETH'S HOSPITAL.

4. THE IMMEDIATE SHORT-FALL IN FUNDS SHOULD BE SHARED BY THE DISTRICT AND FEDERAL GOVERNMENTS.

"ACROSS-THE-BOARD" DIMINUTION IN SERVICES TO THE MENTALLY ILL WILL BE THE INEVITABLE RESULT OF THE FIRING OF PERSONNEL, AND THE CONSOLIDATION AND ELIMINATION OF SELECTED MENTAL HEALTH PROGRAMS AT ST. ELIZABETH'S HOSPITAL. IT IS NOT AT ALL CLEAR HOW, OR IF, THESE LOSSES WILL BE COMPENSATED FOR. THE VICTIMS OF THE BUDGET "CRUNCH" WILL, FOR THE MOST PART, BE DISTRICT OF COLUMBIA CITIZENS IN DIRE NEED OF MENTAL HEALTH SERVICES. THESE CITIZENS WILL NOT BENEFIT FROM THE PROVISION OF ALTERNATIVE SERVICES BY THE DISTRICT, SINCE SUCH SERVICES SIMPLY DO NOT EXIST AT THIS TIME.

ST. ELIZABETH'S HOSPITAL IS A UNIQUE INSTITUTION. IT IS NOT SIMPLY A "STATE" MENTAL HOSPITAL. IN ADDITION TO SERVICING THE ACUTE MENTAL HEALTH NEEDS OF DISTRICT CITIZENS, IT HAS A LONG, ACTIVE, AND ONGOING RECORD IN THE PROVISION OF SPECIAL, INNOVATIVE MENTAL HEALTH PROGRAMS. TWO PARTICULAR PROGRAMS UNDERLINE THIS POINT.

ST. ELIZABETH'S HOSPITAL MENTAL HEALTH PROGRAM FOR THE DEAF (MHPD) HAS BEEN IN EXISTENCE FOR OVER TWENTY YEARS. IT PROVIDES, IN ADDITION TO THERAPY, SERVICES, TRAINING, AND RESEARCH IN THE MENTAL HEALTH NEEDS OF THE HEARING-IMPAIRED POPULATION, AND HAS BEEN THE RECIPIENT IN 1978 OF THE AMERICAN PSYCHIATRIC ASSOCIATION'S GOLD ACHIEVEMENT AWARD. IN ADDITION TO BEING THE ONLY MENTAL HEALTH PROGRAM FOR THE HEARING-IMPAIRED IN THE DISTRICT OF COLUMBIA, IT IS ALSO THE ONLY PROGRAM THAT PROVIDES COMPREHENSIVE MENTAL HEALTH SERVICES TO THE HEARING-IMPAIRED. THESE SERVICES HAVE BEEN PROVIDED TO CITIZENS FROM OVER 40 DIFFERENT STATES. THE TRAINING AND RESEARCH COMPONENTS HAVE SERVED THE NEEDS OF STUDENTS FROM MANY DIFFERENT STATE UNIVERSITIES AS WELL AS FROM FOREIGN COUNTRIES.

ST. ELIZABETH'S HISPANIC PROGRAM ADDRESSES THE SPECIAL PROBLEMS POSED BY THE CONFLUENCE OF INDIVIDUALS WITH MENTAL HEALTH NEEDS AND LANGUAGE-COMMUNICATION BARRIERS. LIKE MHPD, THIS PROGRAM IS COMPREHENSIVE IN DESIGN, PROVIDING A RANGE OF SERVICES, INCLUDING DIFFERENT FORMS OF THERAPIES AND SURVIVAL SKILLS.

BOTH PROGRAMS REPRESENT PROGRESSIVE, "NATIONAL-MODEL" EFFORTS TO DEAL WITH THE UNIQUE ISSUES POSED BY POPULATIONS WHOSE MENTAL HEALTH NEEDS ARE

COMPLICATED BY SEVERE, AND AT TIMES TOTAL, BARRIERS TO COMMUNICATION. THESE EFFORTS REPRESENT AN EVOLUTIONRY ADVANCE IN THE AWARENESS OF THE MENTALLY ILL POPULATION, ITS SUBGROUPS, AND ITS SPECIAL VULNERABILITIES.

COLLAPSING THESE PROGRAMS IN EFFECT ERASES FROM GENERAL AWARENESS THE SPECIAL PROBLEMS THESE PROGRAMS CURRENTLY, SUCCESSFULLY ADDRESS. THE VACUUM LEFT BY THE DISAPPEARANCE OF THESE PROGRAMS IS NOTHING SHORT OF ABANDONMENT OF THESE INDIVIDUALS.

THE ABSENCE OF AN EFFECTIVE TRANSITIONAL PLAN FOR THE TRANSFER OF PATIENTS FROM ST. ELIZABETH'S HOSPITAL TO THE DISTRICT'S COMMUNITY MENTAL HEALTH CENTERS IS RELATED TO THE PRESENT BUDGET APPROPRIATION CRISIS. THERE MUST BE INCENTIVE FOR THE DISTRICT TO ASSUME INCREASING RESPONSIBILITY, SUCH INCENTIVE TO BE ESTABLISHED BY THE FEDERAL GOVERNMENT'S GRADUAL, YET PROGRESSIVE, WITHDRAWAL OF FEDERAL SUBSIDY.

THE SHORTFALL IN FUNDING SHOULD BE ACCOMMODATED - JOINTLY - BY THE DISTRICT AND FEDERAL GOVERNMENTS, IN A FASHION SIMILAR TO THE JOINT RESPONSIBILITY CONTEMPLATED FOR DEINSTITUTIONALIZATION BY JUDGE AUBREY ROBINSON IN THE DIXON CASE.

EITHER THE D.C. APPROPRIATION OR THE ST. ELIZABETH'S APPROPRIATION SHOULD BE INCREASED, OR BOTH SHOULD SHARE THE INCREASE. A PHASED, GRADUAL REDUCTION AND TRANSFER OF FISCAL RESPONSIBILITY TO THE DISTRICT IS NEEDED, AND IT CAN ONLY BE IMPLEMENTED BY A THOUGHTFUL, COORDINATED TRANSITION EFFORT. ANYTHING LESS IS DISRUPTIVE AND FALLS HARSHLY ON THE MENTALLY ILL POPULATION EACH SYSTEM IS DESIGNED TO SERVE. THAT IS A HUMAN TOLL THAT IS MISPLACED, UNDESERVED, AND TOO HARSH TO PAY.

LETTER FROM HON. WALTER E. FAUNTROY, DELEGATE, DISTRICT OF COLUMBIA

The Honorable Arlen Specter
Chairman, Subcommittee on the
District of Columbia
Room SR-152 Senate Office Building
Washington, D.C. 20510

August 4, 1983

Dear Mr. Chairman:

As I am sure you are aware, the House Committee on the District of Columbia has certain legislative and oversight responsibilities for St. Elizabeths Hospital. In this capacity we maintain an active interest in the activities of the hospital working with Alcohol, Drug Abuse and Mental Health Administration and National Institute of Mental Health officials and the hospital administration.

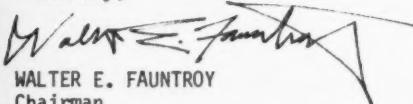
In June of 1982 we requested the General Accounting Office to undertake a feasibility study to determine alternate mechanisms by which an orderly transfer of St. Elizabeths from federal control to that of the District of Columbia could be most effectively accomplished. A team of seven health specialists were assigned to the task by the General Accounting Office. The study is to be submitted to the Committee in October-November of this year. We will then probably hold oversight or legislative hearings on the results.

It has come to our attention that testimony given by officials from Alcohol, Drug Abuse and Mental Health Administration during recent hearings held by your Subcommittee may have suggested that the General Accounting Office is pursuing a specific direction and has revealed its findings to Alcohol, Drug Abuse, and Mental Health Administration staff. It is our understanding after conversation with the General Accounting Office Project Director, Mr. Bill Gerkins, that it is premature to speculate on what the General Accounting Office findings and recommendations will be.

I have taken the liberty to enclose a copy of the correspondence initiating this unique study with this letter and request that both be included as a part of your hearing record.

I want to commend you on your handling of the current budget crisis at St. Elizabeths. Please know that I and/or Committee staff is available to work with you or your staff toward a satisfactory solution of the St. Elizabeths question.

Sincerely,



WALTER E. FAUNTROY
Chairman
Subcommittee on Health and Fiscal Affairs

LETTER FROM HON. CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES

The Honorable Ronald V. Dellums
Chairman, Committee on the
District of Columbia
House of Representatives

June 22, 1982

Dear Mr. Chairman:

We have received your request of June 8, 1982, for a review by the General Accounting Office of various factors

relating to the question of transfer of Saint Elizabeths Hospital to the Government of the District of Columbia.

This request, which as your letter suggests, has been discussed between our respective staffs, is assigned to our Human Resources Division. Staff from that division will be in periodic contact with the committee staff to discuss this review as it progresses.

Sincerely yours,



Comptroller General
of the United States

LETTER FROM HON. ROBERT V. DELLUMS, U.S. REPRESENTATIVE FROM CALIFORNIA

The Honorable Charles H. Bowsher
Comptroller General of the United States
441 G Street, N.W.
Washington, D.C. 20548

June 8, 1982

Dear Mr. Bowsher:

In 1975 the House Committee on the District of Columbia was assigned legislative and oversight responsibilities for Saint Elizabeths Hospital. Following a series of hearings which disclosed certain facility and managerial deficiencies, and the subsequent loss of accreditation by the Joint Commission on Accreditation of Hospitals, a commitment was made to the Committee by then H.E.W. Secretary Joseph Califano, whereby those needed corrections in the facility and management would take place with a goal toward receiving a two-year J.C.A.H. accreditation. Monies were appropriated and with the assistance of Committee staff this goal was reached in October, 1981, with Saint Elizabeths receiving an unqualified two-year J.C.A.H. accreditation. With the accreditation the first phase of the 1977 H.E.W. commitment was completed.

The second phase of the commitment encompasses the question of the transferring of Saint Elizabeths from the Federal Government to the Government of the District of Columbia. Since 1969 the notion of a transfer of some kind has been in the works and is unresolved. At my request, Committee staff has reviewed the various Federal and District proposals concerning the relation of Saint Elizabeths to the District of Columbia.

It seems that insufficient attention has been on how a transfer could be accomplished, taking into consideration all parties involved in the governing of Saint Elizabeths, all of lands, patient care and future needs by the District of Columbia as it pertains to acute and long-term mental health care of its citizens. We now formally request such a feasibility study based on the outline for same submitted to us by G.A.O. staff on June 4, 1982, and are confident that this report will give us the kind of analysis which will allow us to draft the appropriate legislation. I am sure we can live with the suggested time frame for completion provided we are given progress reports at regular intervals as has been discussed. Our mutual staffs can decide on how often these should and can be done.

We look forward to this opportunity of working with you and are grateful of your willingness to consider this task.

Sincerely,

RONALD V. DELLUMS
Chairman, Committee on the
District of Columbia

OUTLINE OF AREAS OF INQUIRY
FOR
REVIEW OF THE FEASIBILITY OF TRANSFERRING ST. ELIZABETHS
HOSPITAL TO THE DISTRICT OF COLUMBIA

The overall objective of the feasibility study would be to develop one or perhaps several alternative methods for accomplishing the transfer of St. Elizabeths hospital from the Federal Government to the District of Columbia. It would focus on how to transfer the facility and not on whether it should be transferred.

The initial data gathering phase of the assignment would have two focal points, St. Elizabeths and the community and would address how St. Elizabeths could be integrated into the overall D.C. mental health care system.

ST. ELIZABETHS BASED EFFORTS

At St. Elizabeths we would have to do work in the following areas.

--Patient survey: Inventory the current patient workload into District vs. non-District patients and determine the appropriate level of care for these patients.

Indications are that such patient surveys have been done in the past, and the result would be a sharp reduction in the number of patients who would be District patients needing inpatient care.

--Land and Buildings survey: Assess what buildings at the St. Elizabeths complex are needed to support the inpatient hospital needs and the Area D community mental health center, and what buildings could be used for alternative levels of care (nursing home, etc.) The assumption is that excess land and buildings would be sold, and the proceeds would be put in trust

with the income from such trust going to defray the operating costs of the restructured complex.

- Staffing survey: Assess what professional and support staff are needed to operate the restructured inpatient complex. Assess what staff could be transferred to provide care in alternate settings.
- Area D CMHC Activities: Assess how the CMHC outpatient activities are now integrated into the St. Elizabeths operations and how the restructuring of the complex would impact on those activities.
- Training Activities: Determine what medical and other training is now provided at St. Elizabeths through affiliations with various area medical schools (GW, Georgetown, etc.) and other mechanisms. Assess what impact restructuring the St. Elizabeths complex would have on such training programs.
- Research Activities: Determine (1) what research activities are now carried out at St. Elizabeths and (2) how NIMH (and other sponsors) would view continuing their research once the complex was restructured and transferred to the District.

COMMUNITY BASED EFFORTS

The community based efforts would include the following areas:

- Analysis of the existing D.C. mental health program: Assess the total D.C. mental health care system including its funding, how emergency and outpatient services are provided, how the alternate care program works (referrals to nursing homes, foster homes, etc.) and finally how the St. Elizabeths inpatient hospital should fit into that overall system.
- Survey of alternate care facilities: Inventory the existing alternate care resources (nursing homes, group homes, community hospitals, etc.) in the District. Determine the combined demand being placed on these resources by St. Elizabeths, Forest Haven, offenders and others. Identify additional facilities that could be used for or converted to alternate care facilities.
- Review of D.C. Medicaid Plan: Transferring patients out of the inpatient hospital to a lower level of care setting should stimu-

late the District to seek Medicaid reimbursement for many of these patients. Analyze the D.C. Medicaid plan to get an understanding of the extent of coverage under existing plan and whether any changes should be recommended.

--Consultation: Because of the interest in the subject of transferring St. Elizabeths, its sensitivity and the number of organizations that will be impacted in some way, contact would have to be made with several organizations. The initial contact would involve explaining our work and obtaining the points of view of these organizations. Later we would bounce specific ideas and proposals off the same organizations. The organizations would include:

1. JCAH
2. D.C. Psychiatric Society
3. D.C. Government officials
4. Mental Health Association
5. Labor Unions
6. HHS officials

The initial data gathering phase of the work would require at least 4 months of effort. Work at St. Elizabeths and in the community would proceed concurrently.

* * * *

The second phase of our work would involve (1) analyzing the data we have reviewed and/or developed, (2) constructing one or more proposals for transferring St. Elizabeths and (3) checking out such proposals with various interest groups.

Specific proposals would be developed for:

1. The appropriate size of and buildings to be used for the St. Elizabeths inpatient facility.
2. The appropriate staff for the restructured St. Elizabeths inpatient facility, and the staff requirements for the needed alternate care facilities.
3. The amount of land and buildings that could be sold at the

St. Elizabeths complex and an estimate of the yield and approximate trust fund income. The legal implications of this would have to be explored with our General Counsel.

4. A patient transfer scheme that would match up patient needs with specific types of alternate care facilities. It would also include identifying sources of additional alternate care facilities.
5. Recommended ways of handling research, medical training, non-district residents, emergency services, and outpatient CMHC activities.

Estimates would also be developed concerning the financial or budget implications of the transfer and future operating costs.

We estimate that this phase would also take about 4 months and at that point we would be in a position to orally present the results of our work. Development and issuance of a written report would probably take another several months.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SAINT ELIZABETHS HOSPITAL

The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, is pleased to have this opportunity to present a brief statement on the immediate budget for Saint Elizabeths Hospital and the longer-term issues confronting the Hospital's future role in the District's mental health system.

Immediate Issue

For FY 1984 the President proposes essentially an effective 20% reduction in the Hospital personnel ceiling, along with inclusion in this permanent ceiling of trainees and patient hires. These proposals, if accepted by the Congress, will

require a disrupting reduction-in-force, will jeopardize the Hospital's hard-won JCAH accreditation and continued eligibility for Medicare reimbursement, seriously impair the quantity and quality of needed services now being provided the seriously mentally ill of the District of Columbia, and greatly handicap or make impossible the operation of training programs.

While the St. Elizabeth's budget should be scrutinized annually for possible savings and program effectiveness (like other Federal accounts), the magnitude, abruptness, and sweeping nature of the Administration's FY 1984 proposals strike at the heart of the Hospital's present basic mission.

Today St. Elizabeths is overwhelmingly the major local resource for inpatient psychiatric care, including hospitalization of emergency patients, committed patients, and forensic patients -- all categories requiring a high level of professional care. Patients enter the Hospital when their mental condition requires the fully structured intensive treatment environment of an inpatient setting; return to the community for follow-up care and rehabilitation depends upon the patient's response to treatment and, to a very substantial degree, upon the availability in the community of appropriate psychiatric and social services. Unfortunately, such community services in the District of Columbia remain underdeveloped and have been the subject of long-standing litigation (the Dixon class action suit brought by the D.C. Mental Health Law Project).

There is no indication that in FY 1984 the service demands on the Hospital will decrease, either because of reduced numbers of persons in the community needing inpatient care or because of expanded services to be provided by other sources. Indeed, on both counts, present indications point in the opposite direction.

Accordingly, the American Psychiatric Association strongly recommends the following: 1) that the FY 1984 permanent personnel ceiling for St. Elizabeths Hospital remain at the FY 1983 level;

2) that trainees and patient hires remain outside the computation of full-time-equivalent positions; and 3) that in FY 1984 the Hospital receive an indefinite Federal appropriation as in past years.

The Longer-Range Issue

The above recommendations for FY 1984 are made in the context of a long-unresolved and fundamental problem, viz., the locus of management, financing, and revised mission of St. Elizabeths Hospital in terms of changes in the mental health service delivery system in recent decades and the need in the District of Columbia for an integrated service system combining into one operation both inpatient and community programs for the mentally ill.

The following brief background information is provided to place this problem in clearer perspective.

Saint Elizabeths has a long distinguished national tradition of leadership and innovation in the mental health field. Since 1855 it has consistently provided services of high quality to the mentally ill of D.C. and eligible Federal beneficiaries. For many years, the Hospital has provided sound training for thousands of mental health professionals over a wide range of disciplines -- a program that has contributed greatly to the quality of professional services (while at the same time being highly cost-effective) and which has been a major source of recruitment of permanent professional staff for both the Hospital and public service mental health facilities in D.C. Finally, through its programs of research and clinical care, St. Elizabeths has for more than a century made important contributions to new knowledge and improved treatment of major psychiatric disorders.

During the past two decades, significant changes have occurred nationally in the mental health service delivery system, partly due to introduction of effective pharmacotherapies for the psychoses, and partly due to expanded networks of community-based mental health services and social support for the deinstitutionalized and uninstitutionalized mentally ill. As a consequence, the daily inpatient census of mental hospitals throughout the country (including SEH) has gradually declined to present relatively stable levels. At the same time, inpatient facilities have usually increased linkages with community-based programs and have focused their efforts more and more on patients who are most difficult to treat and whose condition requires an inpatient setting.

As these changes took place, St. Elizabeths continued to be operated as a Federal entity, while community programs remained a D.C. responsibility. Further, during this period there was a progressive decline in the proportion of Federal beneficiaries (vs. D.C. residents) receiving care at the Hospital. Today, the great majority of patients are D.C. residents. Financing remains largely a Federal responsibility through annual direct appropriations, supplemented by limited reimbursements from D.C., Medicare, and a few other minor sources.

Over the years there have been various study commissions and other efforts to fashion a long-range solution to the problem of management and financing of St. Elizabeths, including appropriate modifications in the original authorizing legislation (or "Organic Act") of 1855. So far none of these has resulted in sufficient agreement among involved parties to develop and submit to the Congress enabling legislation. Among more recent proposals are two -- for establishment of either a public or private corporation to operate the Hospital along with elements of the D.C. community-based mental health system -- which are still before the OMB.

In view of the Administration's FY 1984 budget proposals for St. Elizabeths and the crippling impact they would have on staff and quality of clinical care programs, it is more urgent than ever that a coherent, professionally sound plan be placed before the Congress for the long-range mission of the Hospital as part of an integrated system for providing care for the mentally ill of D.C. (and continuing eligible Federal beneficiaries). Only in the context of such a plan can rational management and financing decisions be made. In the absence of such a plan, abrupt and major reductions in budget (such as proposed by the Administration for FY 1984) serve only to complicate the problem, may well restrict future options, and, of greatest concern, jeopardize JCAH accreditation and undermine the level and quality of services to the seriously mentally ill of D.C.

LETTER FROM LOUIS PEEPLES, ADMINISTRATOR, COUNCIL 20, AFSCME

The Honorable Arlen Specter, Chairman
Senate Appropriations Subcommittee on
the District of Columbia
129 Dirksen Senate Office Building
Washington, D.C. 20515

August 9, 1983

Dear Senator Specter:

On behalf of Council 20 of the American Federation of State, County and Municipal Employees (AFSCME), I would like to express concerns about recent Administration proposals on St. Elizabeth's Hospital. Council 20 represents more than 16,000 public employees in the District of Columbia including the majority of employees at St. Elizabeths.

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), in addressing a possible \$25 million budget deficit at the Hospital, has requested St. Elizabeths to develop a plan that could mean the lay-off of over 650 employees accompanied by cuts in the alcohol and drug abuse program and cutting programs that serve Hispanics and persons from the Virgin Islands, adolescents and children, and the deaf. It is Council 20's position that these proposals again reveal the current Administration's insensitivity to the mentally ill and the poor people of this country who cannot afford private health care.

St. Elizabeths Hospital was founded in 1852 and has evolved into a world renowned mental institution with excellent programs in mental health training and research. It is currently operated by the Department of Health and Human Services which receives operating and capital outlay

funds through the Congressional appropriations process. In addition, the District of Columbia government partially reimburses the hospital for the cost of inpatient care furnished to its residents.

A "contingency" plan has been developed to address a possible \$25 million deficit in St. Elizabeths funding. While the federal government, the District of Columbia and the Congress must negotiate the budget authority, AFSCME Council 20 believes the Administration proposal unconscionably places the psychological burden of these budget negotiations on patients and employees of the hospital.

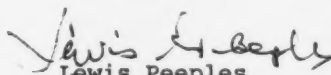
Council 20 represents virtually all of the non-medical staff at the Hospital on whom the major impact of the proposed staff cuts would fall. Our members perform quality services and are specially trained to work under the unique conditions at St. Elizabeths. For example, our members in the dietary unit work in the cafeterias and come into daily contact with patients. They help provide a pleasant environment and are trained to note any change in patient behavior that may be a cause for concern. Additionally our housekeeping and ground-maintenance workers work side by side with patient hires and come in direct contact with patients, again providing a "therapeutic" relationship with patients. In essence, our members not only perform their assigned duties but also provide "support" services for the patients and the medical staff. As such they play an integral and essential part of the mental health care provided at the hospital.

The status of St. Elizabeths hospital has surfaced and resurfaced. The almost yearly "crisis" has created stress and anxiety. Administration development of such a plan before the legislative process is complete only increases tension and reveals an insensitivity to the staff and patients. Further, if these unconscionable reductions are imposed, the hospital's accreditation may be thrown in jeopardy and it may be found to be in contempt of the Dixon vs Heckler litigation in the United States District Court.

The current proposal will have a detrimental impact on patients, staff, and the community. While Council 20 realizes that the funding inconsistency must be resolved, we urge that patients and staff at St. Elizabeths not be made the political football to achieve any budgetary goals. We further urge you and members of your Committee to take any action necessary to prevent any cuts in programs and staff at the Hospital and preserve the institution as a mental health training and research institution for the nation.

We would appreciate your inserting this letter as part of the official record.

Sincerely,


Lewis Peebles
Administrator
Council 20

STATEMENT OF JUANITA THORNTON, CHAIRPERSON, DISTRICT OF COLUMBIA
COMMISSION ON AGING

I am Juanita Thornton, Chairperson of the D.C. Commission on Aging, the citizens advisory group to the Mayor, Council and Office on Aging on the needs and concerns of older Washingtonians. The main function of the Commission on Aging is to advocate on behalf of the District's 103,000 senior citizens.

In this capacity I wish to submit for the record the Commission's opposition to the proposed firing to 653 employees at St. Elizabeths Hospital by December 1. It is our understanding that the actual reduction in force will be closer to 900 employees, as those persons who retire are not to be replaced.

We are deeply concerned as to the impact such a reduction will have on the quality of patient care at St. Elizabeths. Elderly psychiatric patients are an exceedingly dependant population that require a constant level of care. Thus we are especially concerned over the proposed decrease in maintenance staff. Unclean conditions are never conducive to good health.

The Commission on Aging has worked very closely with St. Elizabeths Hospital during the past several years to assure that elderly patients not yet ready for court ordered deinstitutionalization are not placed in the community, and for those that are, that proper social services are in place prior to discharge. Thus we are very familiar with the difficulties confronting District government in trying to provide adequate care for these patients. The elderly truly belong in the "most difficult to place" category. The city does not have adequate financial resources to assume these costs at this time. Therefore the Commission on Aging respectfully requests reinstatement of \$25 million dollars to the District's budget for this purpose.

Thank you very much for the opportunity to express our concerns

OVERVIEW OF D.C. COMMISSION ON AGING

D.C. Law 1-24, as amended, which established the D.C. Office on Aging in 1975, also established the Commission on Aging, a citizens advisory group to the Mayor, Council, Office on Aging and the public on the needs and concerns of older Washingtonians. The main function of the Commission on Aging is to serve as an advocate on behalf of the District's 103,000 elderly. This is accomplished through outreach to individuals and institutions as well as to groups and governments.

The Commission's 15 members are appointed by the Mayor with the advice and consent of the Council to serve three year terms and each of the city's eight wards are represented.

As advocates for the elderly, the Commission impacts upon policy development and legislation. It also deals with program monitoring and accountability as well as service evaluation and recommendations.

In the area of policy development, the Commission has been working with St. Elizabeth's Hospital, a Federal mental health facility located in the District, for 2 years to assure that proper social services are in place in the community for elderly patients prior to court ordered deinstitutionalization.

The Commission routinely advocates for passage of legislation beneficial to senior citizens both before the Council of the District of Columbia and up on Capitol Hill. To celebrate Older Americans Month in 1982, the Commission paired about 800 older Washingtonians with Representatives and Senators from their home state during May to discuss aging issues and concerns. More recently, the Commission conducted a city-wide meeting in April 1983 on proposed District Medicaid cutbacks.

Program monitoring and accountability might best be illustrated by Commission activity during FY 1983 in the area of in-home services. Individual Commission members had received complaints regarding the quality of care of certain in-home service providers. After meeting with the responsible government agency, the Commission sponsored a city-wide informational meeting for aging service providers and individuals to learn about government policies and procedures for providing in-home services and to talk with four actual in-home service providers. Commission interest in this area widened to include bringing together District nursing home and hospital social workers, as well as in-home service providers, to discuss the difficult-to-place patient and the need for proper community services to be in place prior to patient discharge.

Transportation is an area that the Commission has engaged in service evaluation and recommendation. The Commission has dealt with insensitive Metro bus drivers, a poorly functioning Medicaid transportation service, and discrimination by taxicabs against elderly and handicapped fares. It is presently working with the Department of Housing and Community Development to improve management and service delivery in senior citizen public housing.

The Commission believes there is a positive solution to every problem and that the solution can be achieved through team work. A good example of team outreach was an S.S.I. Alert. The Commission was concerned that large numbers of senior citizens might not be aware of benefits under the Supplemental Security Income Program administered by the Social Security Administration. They approached both Social Security and PEPCO, the local electric company in an effort to put together a city-wide information campaign. PEPCO agreed to an insert in their regular monthly billing and Social Security printed and distributed approximately 1,500 transit cards in Metro buses.

Regarding structure, the Commission organizes itself along two lines. Ad Hoc Committees are formed around various issues such as crime, housing, health, transportation, etc. When a specific issue or problem arises, an Ad Hoc Committee is formed to deal with it and is then disbanded upon resolution of the problem. Thus these committees actually accomplish outreach and advocacy with the various branches of District and Federal government and relate the Commission as a whole to other private organizations.

Secondly, the Commission organizes itself on a ward by ward basis using Mini-Commissions on Aging. During 1980, the Commission on Aging established Mini-Commissions on Aging in each of the 8 wards of the District. Mini-Commissions work on problems that are unique to the individual ward, and each of the 8 wards in the District are really quite different. Mini-Commissions identify and resolve local problems as well as carry forward to the Commission as a whole issues which impact upon the city's entire elderly population.

The following is a list of Commission members and the wards they represent as of July 1983:

Dr. Alvis Adair 711 Quackenbos Street, N.W. Washington, D.C. 20011 Ward 4 Home: 882-2814 Work: 636-7318, 483-2364	Ms. Marcela Davila 1235 Shepherd Street, N.W. Washington, D.C. 20011 Ward 4 Home: 723-9556
Mr. James Booze 1724 Lang Place, N.E. Washington, D.C. 20002 Ward 5 Home: 399-2834 Work: 389-2063	Ms. Alice Ford 1443 Channing Street, N.E. Washington, D.C. 20018 Ward 5 Home: 529-6527
Ms. Jane Bristol 1520 Corcoran Street, N.W. Washington, D.C. 20009 Ward 2 Home: 667-9026	Ms. Phyllis Ford 1509 35th Street, S.E. Washington, D.C. 2002 Ward 7 Home: 581-2290
Ms. Audrey Buckner 4306 Wheeler Road, S.E. Washington, D.C. 20032 Ward 8 Home: 574-0177 Work: 678-4300	Rev. Mr. Joseph Frazier 4129 Anacostia Avenue, N.E. Washington, D.C. 20019 Ward 7 Home: 396-2451 Work: 584-8322
Rev. Mozelle Fuller 624 - 17th Street, N.E. Washington, D.C. 20002 Ward 6 Home: 397-7209 Work: 397-7748	Ms. Juanita Thornton, Chairperson 1433 Juniper Street, N.W. Washington, D.C. 20012 Ward 4 Home: 829-5812
Ms. Marguerite Gilmore 4000 Tunlaw Road, N.W. Washington, D.C. 20007 Ward 3 Home: 965-2144	Ms. Mildred Washington 801 Rhode Island Avenue, N.W., Apt. #201 Washington, D.C. 20001 Ward 2 Home: 232-6775
Ms. Karen Mayers 3217 Macomb Street, N.W. Washington, D.C. 20008 Ward 3 Home: 363-7397	Ms. Ruth Webster 1356 Oak Street, N.W. Washington, D.C. 20010 Ward 1 Home: 387-1724
Ms. Geneva Simms 3700 9th Street, S.E., #1119 Washington, D.C. 20032 Ward 8 Home: 574-8632 Work: 724-4370	

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

TUESDAY, SEPTEMBER 27, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:33 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

DISTRICT OF COLUMBIA

OFFICE OF THE BUDGET

STATEMENT OF BETSY REVEAL, DIRECTOR

Senator SPECTER. Good morning, ladies and gentlemen.

We will begin this hearing of the Subcommittee on the District of Columbia, Committee on Appropriations.

The subject matter of today's hearing relates to the issue of the compensation of lawyers for defense in criminal cases, arising out of the recent settlement where it was agreed that the lawyers would have a raise in compensation to \$35 an hour. This matter has come to the attention of the subcommittee when Mayor Barry raised the question with me about the possibility of some funding for this settlement, arising in the D.C. appropriations bill. It came up in the specific context wherein it became apparent that a \$1.5 million appropriation on the Senate side, on the merit pay issue for teachers, would not be fully used because of a revised estimate that it could be accomplished for some \$350,000, and Mayor Barry asked if those extra funds might be allocated in partial payment for the cost of the lawyers' settlement, which was somewhere in the neighborhood of some \$4 million.

I told Mayor Barry that I would be sympathetic to that kind of a reallocation, but would want to consult with the members on the House side, and during the conference last week the subject was raised by me and Congressman Dixon, while sympathetic to the general need, commented that there were other requirements for the District of Columbia and did not want to make a commitment without studying the matter in some further detail.

At the same time, as I commented in the conference, I had been contacted by a number of people who had raised a concern about an FTC investigation into the activities of the lawyers on a possible action, both

either civil or criminal, or both, arising out of a possible price fixing issue. And as said at the conference, it seemed to me that it would be useful to have a hearing on this subject, really, with the fundamental focus being on the issue, as to what assistance might be given by the Federal Government, if any, to make up the funds necessary to pay the lawyers, and that might be an appropriate forum for consideration of the concerns expressed by some on the FTC matter, because that, obviously, is going to be related to what the District of Columbia is going to have to pay for legal services, and what the Committee on Appropriations may be called upon to do by way of assistance to the District of Columbia through this subcommittee.

We had hoped to have Mayor Barry with us this morning, and I was very sorry to learn yesterday of the Mayor's hospitalization, and we wish him the speediest of recoveries so that he can return to his duties, and we will miss him here this morning, and obviously the city will miss him in all respects as he is incapacitated, until he returns to his job.

OVERVIEW OF CJA PROGRAM

I would like to call first this morning Director Betsy Reveal of the Office of the Budget of the District of Columbia, who is here representing the city, and in the Mayor's place.

Welcome, Director.

Ms. REVEAL. Good morning, Senator. How are you?

Senator SPECTER. We appreciate your being here and look forward to your testimony.

Ms. REVEAL. Mr. Chairman, I did not prepare written testimony for this morning, but I would like to share with you the financial status of the Criminal Justice Act program and our assessment of the impact of the new legislation, which the District Council has passed on first reading. We fully expect that it will be passed on the second reading on October 4.

This fiscal year to date we have spent nearly \$5.9 million for Criminal Justice Act payments. These are payments at the lower rate levels.

Senator SPECTER. How much is that again?

Ms. REVEAL. We expect to spend nearly \$6.2 million by the end of this fiscal year.

As you know, there is about a two to four—

Senator SPECTER. Are you talking about fiscal year 1983?

Ms. REVEAL. Fiscal year 1983, that is correct. And that is payment at the lower fee level.

The proposed legislation that has been passed by the District Council on first reading would increase the in-court costs from \$30 to \$35; the out-of-court costs from \$20 per hour to \$35; the maximum payment for a felony case from \$1,000 to \$1,700; and the maximum misdemeanor case payment from \$400 to \$900. Posttrial matters would be increased from \$1,000 to \$1,700.

The D.C. courts—

Senator SPECTER. \$1,000 to \$1,700 posttrial?

Ms. REVEAL. That is correct.

Senator SPECTER. For a felony?

Ms. REVEAL. For a felony, from \$1,000 to \$1,700.

Senator SPECTER. That is what you said, but how about posttrial; is that posttrial?

Ms. REVEAL. That is also \$1,000.

Senator SPECTER. On a misdemeanor as well?

Ms. REVEAL. That is correct.

Senator SPECTER. On any posttrial, from \$1,000 to \$1,700?

Ms. REVEAL. That is correct. The District of Columbia court system—and we agree with their estimates—has estimated that the cost of these increases in fiscal year 1984 will be approximately \$4.2 million.

In a letter that the Mayor sent to Judiciary Committee Chairperson Rolark on September 16, 1983, he indicated his willingness to seek a supplemental or reprogramming during the course of fiscal year 1984.

Senator SPECTER. That letter was sent to whom?

Ms. REVEAL. To Council member Rolark, who is the chairman of the District of Columbia Committee on the Judiciary. We have agreed that we will initiate the necessary supplemental and reprogramming actions at some point during fiscal year 1984.

Senator SPECTER. You talked about reprogramming; that means you expect to find the \$4.2 million within existing D.C. funds?

Ms. REVEAL. If there are not additional funds provided, that is correct.

Senator SPECTER. Well, your chances of additional funds would be diminished if you can find it otherwise, I suppose?

Ms. REVEAL. That is true. But we have made a commitment, and we have realized the legislation will actually take effect some time into the late first quarter of the fiscal year, so the actual cost in 1984 may be somewhat less than \$4.2 million.

Senator SPECTER. When is it that you expect the cost to go into effect?

Ms. REVEAL. The second reading of the legislation, I believe, is October 4, and the Mayor would then sign the legislation shortly thereafter. It then depends on the legislative days in Congress in terms of the layover period.

Senator SPECTER. What is that date again?

Ms. REVEAL. October 4 is the next legislative session of the Council.

PREPARATION TIME VERSUS TRIAL TIME

Senator SPECTER. On the time of waiting time and trial time, what happens to preparation time, or is there preparation in these cases?

Ms. REVEAL. There is preparation in these cases and I believe, although I would like to ask that your other witnesses confirm this, that the out-of-court fees cover the preparation time.

Senator SPECTER. Are they segregated out of court costs?

Ms. REVEAL. Yes.

Senator SPECTER. What are they?

Ms. REVEAL. The fee would go up from \$20 to \$35 for out-of-court costs. I cannot tell you the distribution of our actual payments this year.

Senator SPECTER. The time you mentioned before, which was court time and waiting time?

Ms. REVEAL. In court, out of court.

Senator SPECTER. Well, I see. So it had been \$30 for in court, even if the lawyers were waiting at that time?

Ms. REVEAL. I believe that is correct. But I would have to ask the trial lawyers.

Senator SPECTER. I am getting negative headshakes in the audience.

Ms. REVEAL. No?

Senator SPECTER. You are being coached.

Ms. REVEAL. Thank you.

I will have to turn around and watch the coaches here.

ESTABLISHING THE FEE STRUCTURE

Senator SPECTER. How was the figure of \$35 reached?

Ms. REVEAL. The figure was proposed by the Council. It was not a figure that was developed by the Office of the Budget or the executive branch.

Senator SPECTER. Who comprises the Council?

Ms. REVEAL. It is the District of Columbia Council. Council member Rolark's committee prepared the draft—

Senator SPECTER. When you say the Council, you mean the District of Columbia Council?

Ms. REVEAL. That is correct.

Senator SPECTER. And they had proposed \$35?

Ms. REVEAL. That is correct.

Senator SPECTER. And they negotiated with the lawyers?

Ms. REVEAL. This legislation has been proposed several times in the past, Senator, and has been something that both Chairman Clark and Council member Rolark have worked on over a long period of time.

Senator SPECTER. But aside from the legislation, there was a compromise reached?

Ms. REVEAL. My understanding of the agreement with the trial lawyers was that we had indicated the Mayor's support of the proposed legislation. The Council had indicated to the trial lawyers that that legislation was likely to receive favorable action and, in fact, it did, on the day following the settlement.

Senator SPECTER. Did you have any part in negotiating with the lawyers?

Ms. REVEAL. No, I did not.

PAYMENT TO OUTSIDE LAWYERS

Senator SPECTER. What does the District of Columbia pay other lawyers with whom it contracts, on an hourly basis?

Ms. REVEAL. It varies, depending on the nature of the contract and the nature of the action.

Senator SPECTER. What is the most expensive contract that the District has with outside counsel?

Ms. REVEAL. I cannot tell you that off the top of my head. I would certainly be able to check for you and find out.

Senator SPECTER. Can you give me a ball park figure?

Ms. REVEAL. It is normally the going rate of whatever law firm is involved, and whether we are using a partner or whether we are using associates. It really varies by the rate of the law firm.

Senator SPECTER. Have you seen any rates, in your own experience; are you familiar with any rates at all that the city has paid?

Ms. REVEAL. I have seen one contract, where I believe we were getting assistance in rate cases, and were paying about \$60 an hour. But I would certainly be happy to get the information for you, Senator, that would give you some idea.

Senator SPECTER. All right, I would appreciate it if you would.

[The information follows:]

PAYMENT OF OUTSIDE COUNSEL

The payment to outside counsel usually ranges from \$75 per hour for an attorney who has substantial civil litigation experience to \$120 per hour for a senior partner at a leading law firm.

TYPES OF CASES REQUIRING LEGAL SERVICES

Senator SPECTER. What categories of cases do you have legal services in, rate cases, and what else?

Ms. REVEAL. Primarily rate cases, occasionally tax and other finance cases. Others include development cases where we are either working on real estate deals or doing some other economic development program.

By and large, we use our Corporation Counsel's Office for most of our administrative law representation.

Senator SPECTER. What subject matter came up at the conference that we talked about, that legal services were required outside of the city?

Ms. REVEAL. We discussed the St. Elizabeth's issue and our Corporation Counsel's opinion on that. We have not used outside counsel in that case. The street lighting issue, I believe we discussed that, and we have had outside counsel. They are the counsel we normally use for rate cases.

Senator SPECTER. Well, I would very much appreciate it if you would supply me with the payments made by the District to outside counsel during the course, say, of the past 3 years, with the identity of the attorneys, the hourly rate, and the total payments.

Ms. REVEAL. Fine. I think we can do that, Senator.

Our primary users are the Peoples' Counsel and the Public Service Commission, which have the bulk of the outside counsel. They are fully reimbursed by the utility companies for the costs of those services, but I would be happy to provide those lists.

Senator SPECTER. Was your judgment that the figure of \$35 an hour was a satisfactory arrangement for the District?

Ms. REVEAL. Our concern, as you know, was primarily a fiscal one. I would not comment on the hourly rate and its adequacy. I am sure that the trial lawyers affected have some comments to make on that.

Senator SPECTER. Your duties did not encompass a judgment on the propriety of that rate?

Ms. REVEAL. That is correct. We were concerned about——

Senator SPECTER. Who did make that judgment for the city?

Ms. REVEAL. The District of Columbia Council. This was legislation that was introduced by Chairman Clark and was considered by the Council's judiciary committee, and it was there that the rates were established. Our concern was what the fiscal impact was of the legislative action which was taken.

Senator SPECTER. OK. Thank you very much, Director Reveal.

NONDEPARTMENTAL WITNESSES

SUPERIOR COURT TRIAL LAWYERS ASSOCIATION

STATEMENT OF RALPH PERROTTA, PRESIDENT

ACCOMPANIED BY:

KAREN DIXKOSKOFF, ESQ., VICE PRESIDENT

DOUGLAS EURICO ROSENTHAL, ESQ., COUNSEL

Senator SPECTER. I next would like to call on Mr. Ralph Perrotta and Ms. Karen Dixkoskoff.

Good morning. Thank you for joining us this morning.

Mr. Perrotta, you are the president of the Superior Court Trial Lawyers Association?

Mr. PERROTTA. Yes.

Senator SPECTER. And Ms. Dixkoskoff, you are the vice president of the Superior Court Trial Lawyers Association, correct?

Mr. DIXKOSKOFF. That is right.

Senator SPECTER. All right. Did you two have a role in the negotiations for the agreed upon figure? Before you answer that question, you have a curious situation here. Obviously you are not in custodial interrogation. There are no Miranda rights applicable here and you are skilled lawyers, but it will only take a sentence or two to express a concern as to anything you say could conceivably be used against you, whatever you say is a possibility for an admission. I know you are aware of that, but I think it appropriate to say it, nonetheless.

Ms. DIXKOSKOFF. Well, our counsel is here, Doug Rosenthal with us. I am sure he will tell us—take care of us if we need to stop talking.

Mr. PERROTTA. Senator, there have been immunity orders issued actually, in contemplation of our testifying before the Federal Trade Commission within the next 2 weeks.

Senator SPECTER. Has your counsel told you that those immunity orders for testimony before the FTC will be applicable here?

Mr. ROSENTHAL. No, not applicable, but under the circumstances we think it is consistent with their responsibilities, and for them to answer as fully as they can.

Senator SPECTER. I recall a circuit decision where some lawyers got immunity in bar association proceedings and found themselves on the end of a criminal prosecution which was upheld by the Seventh Circuit, a few years back. It is a tricky field.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. But you have got your own lawyer. I will not give you any more thoughts.

NEGOTIATIONS FOR SETTLEMENT ARRANGEMENTS

Mr. Perrotta, did you engage in part of—were you a party to the negotiations for the settlement arrangements?

Mr. PERROTTA. Yes.

Senator SPECTER. Would you describe those for us, please?

Mr. PERROTTA. Well, actually, the negotiations were only around the bill which was proposed by Chairman Clark and Chairperson Wilhelmena Rolark. There was never any negotiation about that bill, except that there were some people among our membership who were insistent that we ought to be holding out for a much higher rate than was proposed in the bill. The bill was \$35 an hour from the beginning. We had no part in determining that \$35 an hour figure; it was simply there as a bill. When the bill came up for public hearings in April, I believe it was, we testified in support of it, as did the president of the D.C. bar and a number of other people.

So in that sense, there was no negotiation. The negotiation had to do with the suggestion by some people who took cases at the Superior Court, that the bill was too modest, since we had not had any increase in 13 years, and that even the \$35 an hour was considerably lower than what lawyers ordinarily charge for comparable services in private practice. We ought not settle for \$35 an hour.

CHARGE FOR COMPARABLE SERVICES IN PRIVATE PRACTICE

Senator SPECTER. What do lawyers customarily charge for comparable services in private practice?

Mr. PERROTTA. Well, to the extent that there are retained cases, retained criminal cases—there are not very many, but there are some—it is not unusual for a person to be charged \$1,500 to \$2,000 for a misdemeanor defense and \$4,000 to \$5,000 for a felony defense.

Senator SPECTER. It is not unusual to be charged that much?

Mr. PERROTTA. That is right, sir.

Senator SPECTER. It is not unusual to be charged a lot more, either, is it?

Mr. PERROTTA. No, it is not. It certainly is not unusual to be charged a lot more, depending upon how much the client can afford. We never even—we hardly ever approach—

Senator SPECTER. Aside from what the client can afford, what the lawyer's charges are.

Mr. PERROTTA. That is right, sir. No denying that.

Perhaps we might, while I am here, your honor, if I might answer a couple of questions you asked the city's Budget Director regarding in-court and out-of-court time.

TWO CATEGORIES OF PAYMENTS

There are two categories of payments under the existing law, at \$20 and \$30 an hour for out-of-court and in-court time, respectively. I did a check of about a dozen vouchers of mine which I had submitted recently, and the out-of-court costs are about 85 percent of the overall costs.

The in-court costs do not include waiting time. They simply include time actually before the bench, arguing the motion for trial.

Senator SPECTER. Well, the figure had been \$20 and \$35. Now, that had been represented to me to be \$20 for waiting time, \$35 for—

Mr. PERROTTA. Twenty dollars for waiting time, among other out-of-court expenses.

Senator SPECTER. I see. So preparation time was charged at \$20 an hour?

Mr. PERROTTA. Yes, that is right.

Senator SPECTER. And now all time will be charged at \$35 an hour?

Mr. PERROTTA. Yes. So there will no longer be any distinction.

Senator SPECTER. How many lawyers from the D.C. bar participate in providing these services?

Mr. PERROTTA. Well, Mr. Polansky tells us—we have not been able to get precise figures from him, but he tells us that there are as many as several hundred lawyers who take some cases, but there are about 100 lawyers who practice actively and regularly representing criminals.

Senator SPECTER. And these are lawyers who maintain private offices, who have other kinds of cases, civil cases, other criminal cases, general practice, or whatever their practice may be?

Mr. PERROTTA. Some do and some do not. There are a cadre of people who take almost exclusively criminal cases under the voucher system, and then there is a whole spectrum that varies from people who take a few criminal cases to people who take mostly criminal cases.

Senator SPECTER. But all of these people maintain their own offices and have their own overhead to pay?

Mr. PERROTTA. Yes, no doubt about that.

AVERAGE OVERHEAD FOR PRACTICING LAWYERS

Senator SPECTER. Well, what is, in your judgment, the average overhead, on an hourly basis, for a practicing lawyer?

Mr. PERROTTA. Well, of course, a good many people do not feel that they can afford to have offices at all, except at home, and consequently they have very little overhead, but of course, that results in different kinds of inefficiencies. It means that you end up typing your own motions, doing your own clerical work and—

Senator SPECTER. Do you get paid \$20 an hour for that?

Mr. PERROTTA. You are not allowed to bill for clerical work. You simply have to absorb that cost.

Senator SPECTER. Well, assuming you have an office, what is an average cost in overhead per hour for lawyers who have offices, in your professional opinion?

Mr. PERROTTA. I do not know that I could give you a figure.

Senator SPECTER. Do you have an office?

Mr. PERROTTA. No, I have one in my home. I do not have a separate office.

Senator SPECTER. What is your overhead in your home?

Mr. PERROTTA. I do not think I can calculate it with any kind of—

Senator SPECTER. Do you file a tax return?

Mr. PERROTTA. I did, but I have a tax preparer, and I, consequently, am not too familiar with exactly what the deductions he put down.

Senator SPECTER. Do you have overhead?

Mr. PERROTTA. I am sure he deducted something for the portion of my home which I use as an office. I do not know what it is offhand.

Senator SPECTER. How can you figure out what you are going to charge if you do not know what your overhead is?

Mr. PERROTTA. Well, of course, there is no problem what to charge, because the charges are prescribed in the law at \$20 and \$30 an hour.

Senator SPECTER. Suppose your overhead is \$40? Your overhead may be \$40 an hour, for all you know.

Mr. PERROTTA. Well, in my case it is not. But I do know that there are lawyers——

Senator SPECTER. How do you know?

Mr. PERROTTA. Because I live in my home, in any case, and the out-of-pocket expenditures are not significantly different.

Senator SPECTER. Do you have a telephone there that you use for business?

Mr. PERROTTA. Yes.

Senator SPECTER. Do you have a secretary?

Mr. PERROTTA. No, except as I hire one on a piecemeal basis from time to time.

Senator SPECTER. Do you prepare briefs for your clients?

Mr. PERROTTA. Sometimes, yes, when necessary.

Senator SPECTER. Do you have a secretary who does that? Do you hire somebody?

Mr. PERROTTA. Sometimes I do and sometimes it is easier to do it myself, because I type well, and I can write them as I go along.

Senator SPECTER. How many of the lawyers who perform these services, would you say, have offices outside their homes?

Mr. PERROTTA. Oh, perhaps a third to a half.

Senator SPECTER. Do you have any idea what their overhead is?

Mr. PERROTTA. I would be reluctant to generalize, but offices cost at least a couple of hundred dollars a month, if there are secretarial services, phone expenses, and so on. It is easy to get up to \$500 or \$600 a month, even for a very modest office.

Senator SPECTER. For an office and secretarial services?

Mr. PERROTTA. Yes, for a very modest office and secretarial services.

Senator SPECTER. Do you know of any lawyers who have offices and secretaries for \$500 or \$600 a month?

Mr. PERROTTA. Yes.

Senator SPECTER. Full-time secretaries?

Mr. PERROTTA. No, usually not.

Senator SPECTER. Ms. Dixkoscoff, do you have any more information to shed on overhead for lawyers in this situation?

Ms. DIXKOSKOFF. Well, in the hearings before the City Council there was an attorney who was prepared to testify, and it turned out not to be necessary, because no one was against the bill in terms of the

substance of it. That lawyer had indicated to me that he spends, in the course of a year, approximately \$18,000 on overhead. This is an attorney who does not have a fancy office, who has an office on Fifth Street across the street from the courthouse, who does not have a secretary, but does farm out to a secretary the typing expenses.

Senator SPECTER. \$18,000 a year?

Ms. DIXKOSKOFF. That is correct.

NUMBER OF BILLABLE HOURS

Senator SPECTER. And how many billable hours does he have a year?

Ms. DIXKOSKOFF. He has an extraordinary amount of billable hours. He is one of the few people who make close to the limit. He also works, literally 7 days a week, and is there evenings, so that he has been able to, with the amount of income that he makes, he is able to absorb that. That is very unusual. But if you would—

Senator SPECTER. OK. Back to my question on billable hours. How many does he have, if you know, or if you have any idea?

Ms. DIXKOSKOFF. I am sorry, I do not know the answer to that.

Senator SPECTER. Counselor, could you shed some light on the overhead issue for lawyers who have overhead?

Certainly some of the lawyers who practice here must have overhead. You are a practicing lawyer; you have overhead.

Mr. ROSENTHAL. The uptown lawyers have substantial overhead, as you know. The rental for spaces in the K Street area can be \$35, \$40, \$45 a foot for rental, and secretaries are paid anywhere between, I think, \$15,000 and \$25,000 a year, and there are other expenses with lexis, libraries.

Senator SPECTER. Is your personal overhead, if you care to answer, more or less than \$35 per hour, for billable hours?

Mr. ROSENTHAL. It would be more than that on the rough rule that an attorney's overhead is usually approximately half of what he bills.

Senator SPECTER. Well, that is a rough rule of thumb, but it is very rough considering that some attorneys bill \$60 an hour and some attorneys bill \$300 an hour.

Mr. ROSENTHAL. Under the circumstances, I would say my overhead probably—substantially exceeds \$50 an hour in overhead.

Mr. PERROTTA. Of course, we would like to have some overhead, Senator. That is our situation. The fact that we cannot afford it now means that we cannot provide the kind of service that we ought to be providing people.

QUALITY OF SERVICE PROVIDED

Senator SPECTER. Well, that is an interesting question that I was just about to come to. What is the quality of the service you provide with these kinds of operations?

Mr. PERROTTA. It takes a very, very astute and well organized person to do a good job and still make a good living representing indigents accused of crime.

Senator SPECTER. How good, aside from the quality of living, is made at \$35 an hour, gross? What is the quality of the service which is being provided for the indigents?

Mr. PERROTTA. Well, I think it varies, but I think under the circumstances it is amazingly good. The problem is that over the years, as inflation increases and the rates stay the same, the pressure to take more and more cases to make a decent living is enormous, and people find themselves taking more cases. It is sort of like walking a tightrope, and you keep dancing along, hoping that you can continue to walk it successfully and continue representing your clients successfully.

Senator SPECTER. And maybe either to get to a higher plateau on the tight rope, and have an office, perhaps a secretary.

Mr. PERROTTA. Yes, that is right.

ADVANTAGES AND DISADVANTAGES OF BILL

OF Ms. DIXKOSKOFF. Senator, if I might. One of the reasons that we were so much in support of this rate increase by the City Council was that we would then be in a position to take fewer cases and be able to work more on each individual case.

I have not, in the hearings—I think it is in the information that you have, I discovered that for me to make \$20,000 I have to close 91 cases a year. That means that I probably have taken approximately 150. I have some from the year before, and there are cases that I am going to want to close the following year, and that kind of circumstance, what ends up happening is that people who are dedicated to providing representation to accused people spend a tremendous amount of time trying to juggle all of this.

One of the most unfortunate aspects of the bill which I anticipate will be signed by Mayor Barry is that, one, there is no distinction for in-court and out-of-court work. My experience has been that the most crucial work in preparation is out of court. By the time you get in there you should have everything organized together, know who your witnesses are.

So in terms of the way the bill is structured, I think that the quality of the representation, if some persons have—are economically motivated, are going to tend to generate a lot more of that, so in terms of that aspect of the bill, I think it is quite helpful in providing more than adequate representation.

Second, is that what we are hoping is that the \$35 bill will attract more lawyers. One of the reasons that the situation has been the way it is is that no one has wanted to come down and pick up criminal cases. It has been considered very unattractive kind of thing to do, because of the money, because of the time commitment that you have to spend.

We are hoping that when the \$35 goes into effect, that it will generate more of an interest from attorneys who had been previously disinclined to come down and, hopefully, that will generate some kind of life into the system, and the quality of representation should, I think, become better, because of that.

INVESTIGATORS

Senator SPECTER. What do you do for investigation? Is that chargeable at \$35 an hour?

Ms. DIXKOSKOFF. There are investigators who are paid under the Criminal Justice Act.

Senator SPECTER. So you can get an investigator to be paid separately?

Ms. DIXKOSKOFF. That is correct.

Senator SPECTER. And do you frequently, or customarily do that?

Ms. DIXKOSKOFF. In almost all cases.

Senator SPECTER. You do have investigators?

Ms. DIXKOSKOFF. That is correct.

Senator SPECTER. And how much are they paid?

Mr. PERROTTA. They are paid \$7.50, ordinarily.

Ms. DIXKOSKOFF. Per hour.

Senator SPECTER. \$7.50 an hour?

Mr. PERROTTA. Yes, sir.

Senator SPECTER. And are there an adequate number of investigators available?

Mr. PERROTTA. Well, no, that is always a problem, actually. They tend to be students, and they come and go. Actually, in some ways there are added expenses to the system, because students go back to school. When they are needed for a case, they have to be flown back, and that is not very——

Senator SPECTER. Mr. Rosenthal, in your practice, what do you pay investigators?

Mr. ROSENTHAL. Again, substantially larger fees will be paid for investigators. We get up market investigators, if you need them.

Senator SPECTER. Like what?

Mr. ROSENTHAL. In my area of practice we do not use investigators as much, but often our investigator work is done by paralegals, paralegal assistants, who are often compensated, I guess, at a rate of about—well, some of them are compensated in excess of what Ms. Dixkoskoff is paid for this tremendous load of cases.

Senator SPECTER. How much are paralegals paid in your firm?

Mr. ROSENTHAL. Some of the good paralegals are paid in——

Senator SPECTER. Do you have any others?

Mr. ROSENTHAL. In excess of \$25,000 a year.

Senator SPECTER. And how much on an hourly basis are their rates charged?

Mr. ROSENTHAL. I am less clear on that. The good paralegals, their time is sometimes billed in the area of \$50 an hour.

Senator SPECTER. What are comparable charges in other cities, if you know, Mr. Perrotta?

Mr. PERROTTA. We have a chart which we will submit, Senator. There was an article in the National Law Journal which did an analysis of rates around the country.

[The information follows:]

**REPRESENTING THE POOR:
CRIMINAL INJUSTICE AND EFFECTIVE REPRESENTATION**

The indigent's rights under the Constitution are no less than the rights of the well-to-do. And, yet, if his counsel is not adequately paid, the indigent defendant has little reason to expect that his rights will receive the protection they would get if he could afford to retain counsel.

-- Joint Committee of the Judicial Conference of the D.C. Circuit and the D.C. Bar (Unified), Report on Criminal Defense Services in the District of Columbia ("Austern-Rezneck Report") (April 1975).

The attorneys who are appointed by the court to represent indigent defendants under the Criminal Justice Act (CJA) have not received a pay raise in thirteen years. This neglect has resulted in a crisis in the D.C. Courts. The Sixth Amendment right to counsel is imperiled because CJA attorneys must accept more cases than they can effectively handle in order to make a living. The CJA lawyers cannot provide quality representation at current rates. Despite attempts over several years, neither the city, the Congress, nor the courts have taken any action to raise the substandard rates. These circumstances require the CJA attorneys to cease accepting new cases as of September 6, 1983, until the CJA rates are raised to realistic levels.

I. Pay Rates Under the Criminal Justice Act

When originally adopted in 1964, the federal CJA prescribed compensation for appointed counsel at the rate of \$10 per hour for out-of-court time and \$15 per hour for in-court time. Congress amended the Act in 1970 to bring CJA compensation to its current levels of \$20 per hour for out-of-court time and \$30 per hour for in-court time. This adjustment was made, in part, in order to make compensation for appointed counsel "more realistic in terms of today's [1970's] conditions."

Since then, the Consumer Price Index has risen 147%. Median per capita income in the D.C. area has risen over 180% over the same period. However, no adjustments in the compensation levels prescribed either by the federal or the D.C. CJA have been made

to mitigate these extraordinary inflationary effects or to reflect this meteoric rise in area income.

II. Supporters of a Pay Raise

The current CJA rates have been condemned as inadequate in a series of Judicial Conference and Bar Association reports dating back to 1975. Eight years ago, in fact, the "Austern-Rezneck Report" recommended a rate of compensation for CJA lawyers (\$40/hour) higher than that proposed in legislation currently pending before the D.C. City Council (\$35/hour). At recent hearings, the District of Columbia Bar, the ACLU, the Public Defender Service, Superior Court Executive Administrator Larry Polansky, and the National Lawyers Guild all spoke in favor of the pending bill. The D.C. Bar, in a statement in support of this new legislation, characterizes the current rates as "grossly inadequate."

III. The PDS Contrast

In the District of Columbia, 90% of all defendants are indigent and must be provided court-appointed counsel. Chief Judge Carl Moultrie has estimated that, on an annual basis, the Public Defender Service (PDS) handles approximately 15% of the adult cases. In December, 1982, a study conducted by the Superior Court Trial Lawyers Association revealed, however, that PDS represented only 5% of the indigent defendants locked up over a one-week period. The remaining 95% were represented by CJA attorneys.

The budget for PDS last year was approximately \$3.5 million. In contrast, the CJA budget was approximately \$4.6 million. In other words, PDS received 43% of the total appropriations spent for legal representation of indigents, while representing only 15% of those defendants. This inequity divides indigent defendants into two classes: the smaller class represented by PDS receives full-service representation, while the vast

majority receives insufficient funding for their representation.

It is also illustrative to compare the compensation for CJA lawyers with that provided for PDS. Attorneys starting with PDS are paid \$27,000 per year, plus all normal benefits accorded a government employee. They earn their money. While PDS lawyers are supplied with support services, CJA attorneys must pay for their own. Because of this requirement, CJA attorneys must carry a much larger caseload to earn an annual income comparable to that of PDS attorneys.

The caseload for PDS attorneys is limited to 40 at a time, reflecting a policy decision that an attorney cannot effectively represent more than 40 defendants concurrently. Indications are that the actual caseload for a PDS attorney is, in fact, much less, to allow attorneys to spend more time on each case. According to PDS statistics, the average CJA payment per case was \$219.52 during the fiscal year ending March 1, 1983. A CJA attorney must therefore complete 123 cases per year merely to earn a gross annual income equal to the PDS starting salary -- exclusive of employee benefits.

IV. The Private Bar Contrast

As revealed by the well-respected Survey of Law Firm Economics, the average hourly billing rate for a mid-level attorney (11-20 years of legal experience) in cities comparable to the Washington, D.C. metropolitan area, has risen from \$79 in 1977 to \$123 in 1983. The average billing rate for the most junior attorneys (less than 2 years of legal experience) has risen from \$41 per hour to \$64 per hour in that same period. In other words, within the last six years, privately retained counsel fees have gone up over 50%, but over the last thirteen years CJA attorneys' fees have not increased at all. Moreover, the most junior privately retained counsel now averages an hourly billing rate more than double the highest in-court rate

for even the most experienced CJA appointed counsel and more than triple that for CJA out-of-court time.

It is also interesting to note that support personnel at D.C. Superior Court are better compensated than CJA attorneys. The starting salary for a court reporter at Superior Court, for example, is \$21,000 per year, based on a 40 hour work week and three years' prior experience. Yearly merit raises are received. Should the reporter be required to transcribe a trial, the going rate is \$2.00 to \$3.50 per page, 8 1/2 x 11 inch paper. Since most transcripts are quite lengthy, reporters have the opportunity to make a great deal more than \$21,000 per year. Ironically, therefore, the court reporter often stands to make more money transcribing the case than the attorney makes preparing for and trying it.

V. The Present System and Its Effect on Clients

The system as it now exists virtually conspires both to delay and to diminish the CJA attorney's requested and earned compensation -- even at the current artificially low rates. These rates, together with and the limits on compensation per case, work to destroy the attorney's ability to do the extra measure of work which might be needed to safeguard his or her client's rights.

The vouchers on which the CJA attorney must submit the request for payment require minute-by-minute reporting of all activity, with specific descriptions of the work done, the person interviewed, and the research conducted. Moreover, the vouchers can take up to an hour or more to fill out -- time which is not billable.

In addition, before a voucher is submitted, the case must have concluded. As a result, in particularly lengthy cases, the lawyer may experience a delay of a year or more between appointment to a case and submission of the voucher.

While the CJA regulations require the attorney to submit the

voucher within 60 days of the completion of the case, nothing in the CJA system requires that the attorney be paid within 60 days. An additional delay of at least six weeks before payment is the norm, with delays on trial vouchers often taking months.

Then may come the unkindest "cut" of all. After waiting for weeks, often months, to be paid, attorneys frequently have their vouchers cut arbitrarily by a judge who did not even sit on the case. While a voucher may be cut because it exceeds the statutory limit for a particular case, it is within a judge's discretion to cut a voucher, without explanation, whether it exceeds the limit or not. The attorney's remedy in such situations is virtually non-existent. There is no effective appeal from the decision to cut a voucher.

The CJA system also places an unrealistic maximum limit which may be earned on a case -- \$400 for each misdemeanor and \$1,000 for each felony. These figures are usually met and exceeded long before a case goes to trial. Once the figures are met, the attorney may be forced, in effect, to handle the case for free.

The present payment system compels attorneys to take more cases for which they can be paid, instead of doing work on the case which has already exceeded the payment limit. Due to the resulting necessity of a heavy caseload, the CJA lawyer must be in court almost every day, either picking up cases or attending status hearings, sentencings, probation revocation hearings, and trials. His or her research, writing, office appointments, jail interviews, and phone conferences, must be completed at between court appearances or at night. Because of the inherent delays in the court's overcrowded docket, even an attorney with only two or three appearances on a given day may find that judges require him to be in the courthouse most of the day waiting for his case to be called or heard. This is essentially non-billable time. (The experience of most CJA attorneys is that the judges are reluctant to approve payment for lengthy waiting time.)

Thus, even the most industrious attorney is overwhelmed physically and fiscally. And these factors say nothing about the stress that goes with conscientiously preparing for and appearing at trials, hearings, and other arguments in court every day.

The burdens created by the heavy caseload required to earn a liveable salary are inconsistent with quality representation.

Conclusion

Each year that the hourly rates and the statutory maximums for payment to CJA attorneys remain at current levels, these attorneys will be forced to pick up more cases, resulting in an increased danger that the indigent defendant will not be adequately represented. The Constitution of the United States guarantees the right to counsel. That right is now compromised for indigent defendants in the District of Columbia.

We therefore ask for your support in this important cause -- not only for ourselves, but also for the legal profession and the system of justice which we all conscientiously seek to serve.

[From the Law Journal, Monday, Sept. 26, 1983]

INDIGENT DEFENSE IN CRISIS

WASHINGTON — The walkout here by lawyers who represent indigent criminal defendants is only one recent sign of a mounting crisis in the nation's patchwork system of legal defense for the poor.

Throughout the country, public defenders and private lawyers who accept the burden of defending poor people are up in arms about low pay and a crushing case load, while local governments are straining to cut the cost of legal aid to the poor or to shift it over to state governments.

The result is that lawyers who defend the indigent are turning increasingly to drastic steps — including strikes and lawsuits — in an effort to get more pay and better conditions. They and other advocates for the poor say that ultimately the quality of legal work for the 70 percent of criminal defendants who are poverty stricken is at stake. The more cases the defenders must handle and the more often they leave for better jobs, the lower the quality of legal work for the poor.

At least one observer predicts more protests like the one in Washington. "The D.C. situation is not unusual," said John Arango, director of an American Bar Association project organized to educate leaders of the bar on the situation. "In fact, we're close to a nationwide crisis," he said.

The Washington work stoppage, which the lawyers involved are calling a strike (NLJ, Sept. 19), comes less than a year after attorneys of the New York Legal Aid Society, who are unionized, walked off their jobs to protest low salaries and heavy case loads. (NLJ, 11-8-82.)

And they are certainly not the only recent battles:

- In Seattle, where the city budget for indigent defense was cut 18 percent from last year's levels and contract defenders are paid 30 to 40 percent less than local prosecutors, the American Civil Liberties Union is considering a suit challenging the quality of indigent defense.

- In Michigan, where Detroit-area lawyers successfully sued for \$1 million in back pay and higher fees for indigent defense (NLJ, May 16),

lawyers' groups around the state now are considering similar actions.

- In California, where the governor has cut the budget for indigent defense by half, one of San Diego's major providers of contract indigent defense has filed suit in state Superior Court challenging the standards used by the local courts in awarding a contract to another group. *Defenders Program of San Diego Inc. v. Nitz*, 504828.

- In Vermont, where the state has told private practitioners who represent indigents that they may not be paid again until March 1984 (NLJ, Aug. 29), the state's bar association will meet later this month to consider filing suit against the state.

- In Connecticut, the Connecticut Civil Liberties Union has filed suit in Superior Court in Hartford on behalf of five defendants who have been in jail for periods of two to four years. The CCLU says the public defenders involved have not yet filed appellate briefs for their clients. *Taylor v. Manson*, no docket number assigned.

- In Spokane, Wash., a federal class action challenging the quality of representation by the Spokane County Public Defenders Office prodded the county government to provide more staff attorneys to reduce case loads and the suit was settled in July — one month after it was filed. *Doe v. Spokane County*, C-83-406RJM.

Desperation v. Outrage

Two powerful forces are clashing in these upheavals: the desperation of local governments to save money and the growing outrage of lawyers who find that their compensation lags pathetically behind what other attorneys are earning.

According to figures compiled for an ABA study by University of North Carolina Law Prof. Norman Lefstein, the most common rate of pay for lawyers who defend indigents — be they government-employed public defenders, private attorneys with a contract to defend for a fixed fee or simply individual lawyers accepting court appointments to cases — is about \$20-\$30 per hour, and there is no appreciable rise in compensation for those with greater experience. On the other hand, retained counsel with less

than two years' experience are paid an average hourly rate of \$50, the professor's study showed.

"These lawyers are fed up. They're saying, 'We're mad as hell and we're not going to take it anymore,'" said Richard J. Wilson of the Washington, D.C.-based National Legal Aid and Defender Association.

Mr. Wilson, director of the NLADA's defender division, called the funding of indigents' defense "a national humiliation," amounting to only about 1.5 percent of all state and local government criminal justice expenditures in a society where the police get 53.2 percent; corrections facilities, 24.7 percent; the judiciary, 13.1 percent; and prosecutors, 5.9 percent.

One consequence of lawyers' new militance, according to Robert J. Spangenberg of Abt Associates Inc., the Cambridge, Mass., consulting firm, is that among private lawyers who defend poor people, there is a growing tendency to bring suit to compel payments of adequate fees from local governments.

In one major 1981 case in Iowa, lawyers prevailed in convincing the state Supreme Court that defense attorneys for indigents are entitled to the same fees as retained counsel. *Hulse v. Wifvat*, 306 N.W.2d 707.

Another approach sometimes taken by lawyers is the argument that not paying lawyers for their work on behalf of poor people is a form of involuntary servitude or a taking of the attorneys' property. Such a strategy worked in a roundabout way in a 1981 Missouri case, when a state court rejected the argument and instituted a system whereby every attorney in its jurisdiction became obliged to work on an unpaid basis to defend indigents. *State ex rel. Wolf v. Ruddy*, 617 S.W.2d 64. Suddenly, strong statewide opposition to not paying lawyers materialized, and Missouri later established a state-funded public defender system.

A similar indirect success was scored in Michigan, where the Detroit bar associations intervened when Wayne County sought an injunction from a higher court to bar a judge's order mandating a doubling in the fees it paid defenders of indigents. Through the offices of the bar, the county, which includes Detroit, struck an agreement with the state Supreme Court to phase

in a new fee schedule. *Wayne County v. Chief Judge of the Third Judicial Circuit*, 70647. (NLJ, May 16.)

A recent attempt to raise fees for federal indigent defenders failed, however, when the 7th U.S. Circuit Court of Appeals ruled in *Mills v. U.S.*, 82-2583, that the Judicial Council of the 7th Circuit had no authority to increase attorney fees to levels higher than those set by Congress in the 1970 amendments to the Criminal Justice Act. (NLJ, Aug. 1.)

Lawyers aren't the only ones taking the government to court. Other groups are increasingly likely to sue on behalf of the lawyers' clients.

"There's no question that inadequate fees affect the quality of representation," said Professor Lefstein, "and that increases the probability of a wrongful conviction or an inadequate waiver of counsel."

Fears that quality already is slipping—at least in misdemeanor cases—has prompted groups such as the ACLU to challenge the quality of representation. Gilbert Levy of the Seattle firm of Doherty & Levy chairs a local ACLU committee on indigent defense. He said that when fees are too low, attorneys don't stay in defenders' offices long, and the experience level of lawyers handling complex cases becomes dangerously low. In addition, he said, when case loads get as high as they are in some jurisdictions, a defender "is not able to do an adequate job on every case."

'A Lot of Shifting'

On the other hand the governments have been faced with budgetary crises and defending the poor is not politically popular. As a result, said Mr. Spangenberg, "there has been a lot of shifting around" in the way legal aid for poor people is supplied as jurisdictions have experimented to find the least costly methods.

The average annual increase in costs in a recent two-year period, he said, for running a governmental public defender office was 5 to 10 percent; the average annual cost for a system relying on assigned counsel was 10 to 20 percent; and the increase for a system in which private groups of attorneys contract to defend for a flat fee was 15 to 40 percent.

A typical pattern, Mr. Spangenberg noted, is that of the municipality which adopts a contract approach to save

money (NLJ, 12-14-81), closing its public defender office, only to find that the contractor demands an increase in the fee when it comes time to renew. A number of cities and counties have recently reopened their government public defender offices for this reason, he said.

Mr. Spangenberg, who heads Abt's Criminal Defense Technical Assistance Project, is in the process of completing a comprehensive review of indigent defense funding throughout the country sponsored by the U.S. Justice Department's Bureau of Justice Statistics.

When the results are published in December, he predicted, they will show that local governments are "desperate" to get out of the indigent defense business. "It's an uncontrollable item in their budgets," he said. "There's no way they can accurately predict case loads."

A Lack of Sympathy

But governments do not find many sympathetic hearers among the lawyers who defend indigents, particularly the non-salaried attorneys who depend on fees. In many areas, these people have not gotten a raise in more than 10 years.

Appointed counsel in federal cases, for example, are limited to \$30 an hour for in-court work and \$20 for out-of-court services — figures set by an amendment to the Criminal Justice Act in 1970.

It was precisely that rate of pay

that prompted a walkout by lawyers appointed to represent indigent defendants in the District of Columbia. About 100 attorneys — all members of a group called the Superior Court Trial Lawyers Association — began refusing to take new cases earlier this month to protest the fact that their fees, set under a local criminal justice act modeled after the federal law, had not been raised since 1970.

A great deal of attention has been focused on the D.C. lawyers' "strike," for several reasons. First, the Federal Trade Commission has targeted the strike, which FTC lawyers say is an illegal boycott, for an investigation to determine whether meetings by striking lawyers amount to collusion to fix prices and violate federal antitrust laws. (NLJ, Sept. 12.)

Similar to Doctors' Probe

The probe is similar to one the FTC undertook several years ago against Michigan doctors who had threatened to boycott patients unless state cuts in Medicaid reimbursements were restored. The FTC eventually ruled the doctors' threat illegal.

The D.C. situation is also of importance because the fee structures for Washington defenders are so similar to those for the rest of the country. If the lawyers in Washington end up in court challenging the fairness of their fees, the fact that the fees are identical to those paid federal defenders around the country — as well as many locally paid defenders — could have broad implications, said NLADA's Mr. Wilson.

The Pay in Indigent Cases

THE CHART that follows is a breakdown of the most recent figures available on fees paid to private court-appointed counsel for indigents.

Hourly rates are given for out-of-court work and court appearances, with the out-of-court rate appearing first. Data on fees paid for felony cases and appellate work are also included.

Data for some states show sample county rates only; rates in other counties within the state may vary.

SOURCE: National Legal Aid and Defenders Association

State	Hourly Rate Out-of-Court/ In-Court	Felonies (Excluding murder and capital crimes)	Appeals
Alabama	20/40	\$1,000*	\$1,000
Alaska	40/40	R	R
Arizona	25-30/25-30	1,500	n.a.
Arkansas	n.a.	25-350	350

State	Hourly Rate Out-of-Court/ In-Court	Felonies (Excluding murder and capital crimes)	Appeals
California	20-25/40-45	V ¹	V ¹
Colorado	25/35	3,000	25 hour
Connecticut	12.50 hour ² 75.00 day	12.50 hour ² 75.00 day	R
Delaware	25/35	R ³	R
D.C.	20/30	1,000*	1,000
Florida	20-25/50-65	2,500	1,000
Georgia	20/30	1,000-2,000	500
Hawaii	R	750 maximum	1,500 maximum
Idaho	30-35/30-45	R	R
Illinois	30/30	1,000	1,500
Indiana	35/50	1,500 minimum	1,500 minimum
Iowa	35/40 ⁴	R ⁴	R ⁴
Kansas	20/30	500 — guilty plea 1,000 — not guilty plea ⁵	R
Kentucky	25/35	1,250	750
Louisiana	25/35	1,000*	R
Maine	25/30	1,500	25-30 hour
Maryland	20/25	1,000*	500
Massachusetts	25/35	1,000	R
Michigan	10/50	V ¹	V ¹
Minnesota	20/25	V ¹	V ¹
Mississippi	20/30	500	500
Missouri	15/20	R	R
Montana	30/30	1,000	n.a.
Nevada	20/30	2,500	1,000
New Hampshire	20/30 ⁶	1,500 ⁶	750
New Jersey	15/22.50	22.50 hours ¹¹	n.a.
New Mexico	20/30	800	1,000
New York	15/25	750 ⁸	500
North Carolina	20/30	500-1,000	R
North Dakota	50/50	500 ⁸	50 hour
Ohio	30/40	1,000	750
Oklahoma	No set rate	500	None
Oregon	30/30	V ¹	35 hour
Pennsylvania	15/25	800	500
Rhode Island	20/30	1,000-2,000	750
South Carolina	10/15	500	500
South Dakota	30/40	750	750
Tennessee	20/30	500	500
Texas	10/15	50 day in-court	350 minimum
Utah	35/35	R	R
Vermont	15/15	500 ⁸	R
Virginia	n.a.	200-400	150 maximum
Washington	22-30/22-30	1,800	R ⁹
West Virginia	20/25	1,000*	20-25 hour
Wisconsin	35/35	R	35 hour
Wyoming	35/60	R	R
Federal courts	20/30	1,000 ¹⁰	1,000 ¹⁰

*Excludes Expenses R — Reasonable

(1) Varies by county.

(2) In and out of court.

(3) If above \$500, requires court finding that case is complicated.

(4) *Hulse v. Wifvat* says "reasonable" refers to rates in retained cases.

(5) \$9,000 maximum in exceptional cases.

(6) Higher in exceptional cases.

RATES CHARGED BY INVESTIGATORS

Senator SPECTER. What do they charge in New York City or Chicago, or maybe even Philadelphia?

Mr. PERROTTA. Pennsylvania is \$15 and \$25.

Senator SPECTER. \$15 and \$25?

Mr. PERROTTA. \$15 and \$25, out of court and in court.

New York, \$15 and \$25.

Senator SPECTER. South Carolina is \$10 and \$15, I see.

Mr. PERROTTA. \$10 and \$15, yes. Of course, it is hard to compare, because the District of Columbia is rare and unusual, in the sense that most of its criminal work is done through the voucher system. In most cities, the Public Defender Service does the bulk of the work.

Senator SPECTER. How many times does—how frequent is the petition for new trial on grounds of incompetent counsel?

Mr. PERROTTA. Oh, I think it is very rare. I think it comes up as an appeal issue, perhaps fairly often, but I cannot think of—I could think of only one or two situations in the 3½ years that I have been practicing there when I have actually seen a case reversed for that reason.

Ms. DIXKOSKOFF. If I might address two points.

One is the \$20,000 figure which—of my income is actually less. It is also the gross figure, not the net that I make. Second—

Senator SPECTER. You are looking for \$20,000 gross? What do you make net, then? What is your net figure?

Ms. DIXKOSKOFF. I do not know. I do not know how to calculate it.

Senator SPECTER. Do you file a tax return?

Ms. DIXKOSKOFF. Well, yes, it has been filed. The problem is I do not have the information with me. I do not really recall in terms of a net figure.

COMPENSATION LEVELS BY STATE

The other thing I wanted to raise, though, with respect to the compensation levels by State, I was from Pittsburgh and I had worked at the Public Defender Service in Pittsburgh, and the one thing which was clear, clearly different, I think, in all, at least many of the States, in our situation is the following:

That the Public Defender's Office—we took all of these State criminal prosecutions and there were no outside counsel. But the only time any Federal money, I suppose, except if it goes through the public defender system, was used in Criminal Justice Act cases, was when there would be Federal cases, which were rare, and the Federal Public Defender's Office had a conflict of interest.

At the Public Defender's Office in Pittsburgh, I think there were only three lawyers in that office, as opposed to here, where obviously there are a tremendous number because of the nature of the system, and that frequently Federal cases, a large number of them, are the large drug cases where it appears that many of the clients tend to have quite a bit of money, and it appears that in terms of indigent criminal cases, the only time the Federal Public Defender's Office would get it would be, perhaps, in a classic drug case, some little guy at the end of the alleged drug chain, and that the only time that an appointment would be made

by a private attorney in Pittsburgh would be, perhaps, if there are two little guys at the bottom of what is alleged to be this drug transaction, then they would have to appoint another lawyer, because of competency of counsel. So in terms of the applicability—

Senator SPECTER. Because of conflict or competency?

Ms. DIXKOSKOFF. It could be a conflict, right. The Public Defender's Office would be in conflict in representing both of those indigent criminal cases.

Senator SPECTER. Yes, I understand the situation.

Mr. Rosenthal, let us move on to another point.

ISSUE OF PRICE FIXING

If this issue is pursued as to price fixing, is that going to have any impact on what it will ultimately cost the District of Columbia to pay lawyers to handle these cases, and what it may eventuate in pressure on this subcommittee for further appropriations?

Mr. ROSENTHAL. I am hard put, Senator, to see a direct connection. It seems to me that the greater difficulty would be—and I think the chances of their doing so are remote, if the Federal Trade Commission were to prevail and to obtain a cease and desist order against any future collective activity by trial lawyers, I think it would have a significant chilling effect on their ability to come and appear before you and appear before the City Council and speak up before the courts on reform in the courts.

It would be a disservice that would not be reflected in dollars and cents, but would be reflected in the inability to really press for reforms, of which this compensation is only the beginning. As you know—

Senator SPECTER. Well, if you have a large group of lawyers who are going to be ruled out of handling these kinds of cases and are not prepared to work for \$35 an hour, is there going to be another pool arise to work in the District of Columbia, to work for \$35 an hour? Is your firm prepared to go into this field?

Mr. ROSENTHAL. Our firm would only go into this field to provide a public service where we felt that some way we were capable of—

Senator SPECTER. Well, my question is, Are you prepared to go into this field and work for \$35 an hour?

Mr. ROSENTHAL. The answer is, "No."

SHORTAGE OF LAWYERS THREATENED

Senator SPECTER. Where are the lawyers going to come from if the current lawyers are not going to undertake the cases?

Mr. ROSENTHAL. My guess is that you would—if the \$35 fee were not to be realized, or even if the \$35 fee is realized, but is not increased, or reflects inflation—you will have what you have had in the past, which is a continual turnover of lawyers. There will always be probably some who would be willing to take some of these cases, but you will have a turnover, so you will be losing the expertise of those who do it well; you will have a diminished pool of those who will really come in, and the system will suffer.

I am not sure, though Senator, that it will be directly affected in the budgetary considerations. What it will be, though, is like a teapot boiling, and at some point it is going to explode again in the future, and that is where I think the FTC action has an impact.

If all this pressure builds up in the future and if there is in effect a gag, cease-and-desist order, which threatens people with fines and contempt actions if they try to collectively organize and speak out against these injustices, I think it will have an exacerbating effect and make the next disruption a much more serious one than this one.

Senator SPECTER. Well, how widespread is such a gag order or cease-and-desist order likely to be?

Mr. ROSENTHAL. I think there are serious constitutional problems with such a gag order. I think there are serious constitutional problems—

NUMBER OF PEOPLE AFFECTED

Senator SPECTER. That is not my question. My question is, How many people is it going to affect? If it affects enough people, you then have the issue as to how you are going to find lawyers to do it.

Also, you have—this is part of the cost of doing business I frankly am surprised that there is so little understanding as to what the cost of doing business is, from the lawyers who are here.

Very candidly, from the president and vice president of the association as to what it cost them to do business. But if they are hauled into court as defendants in a civil case or a criminal case, that is not going to be an inexpensive proposition, either by way of dollars or time, and that is part of the cost of doing business.

Mr. ROSENTHAL. You are absolutely right about the time. I think that the antitrust bar will see, or our law firm will see, that the services are provided without compensation, but it will be a dramatic loss to their time and a significant and direct cost.

If I could just respond to the last comment. I think one reason why they are less cost-conscious, as some of us uptown lawyers are, I have been impressed by how really dedicated they are to trying to do the right thing. They do not approach this as business people. They really are committed to trying to provide quality legal service. That makes it appropriately inappropriate to view this in an antitrust context, because this is not basically an economic dispute.

Senator SPECTER. Mr. Rosenthal, if they agree to work for nothing, would that be price fixing?

Mr. ROSENTHAL. I do not think so. I do not think this is price fixing. I do not think it is a so-called economic boycott, reached under the antitrust laws.

I did not answer your direct question. I do not know of any attempt anywhere else in the United States that has succeeded to put such a gag order on the lawyers doing this kind of activity.

Furthermore, I think there are substantial problems with an FTC gag order here, because if the Trial Lawyers Association were subjected by court order to such a cease-and-desist order, I think the organization would probably go out of business, and some other rump group, which

might be significantly more radical and represent other fringe interests, might coalesce a new group, and would not be subject to the order, so the FTC action would be ineffective.

Senator SPECTER. Well, the replacement group might cost substantially more than \$35 an hour, too.

Mr. ROSENTHAL. That is correct; that is absolutely correct.

Senator SPECTER. Well, that is one possible concern that the District would have and that the Appropriations Committee might have.

Mr. ROSENTHAL. Well, I think that is a fair point. There were a number of lawyers who were dissatisfied with this settlement and thought that the lawyers should have held out for \$55 an hour, or \$55.45.

Senator SPECTER. Well, if you had the settlement reached at \$35 an hour, and it is going to be shaken some way by collateral action, be it by the FTC or the Justice Department, in any way, then the city is going to look to find counsel for the indigents.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. And then the city is going to be calling up the D.C. Appropriations Subcommittee and wanting to get some help on paying for it, and what you have at a bargain basement rate, or subbasement, or subunnel, at these rates, is very likely to be increased.

Mr. ROSENTHAL. I appreciate your clear eye on the economic ball. I think you are seeing something that I had missed. That is right. If this system is made unworkable, one of the options—one of the few options that there may be for the city is to set up a public defender program which takes all of these cases.

COST OF FULL-TIME PUBLIC DEFENDERS

Generally, I think the experience is that it costs the city a great deal—it costs a great deal more money to pay full time public defenders, to provide them with health benefits and pension programs, which are not provided to these lawyers, and if the city had to do that, it would cost the city a great deal more money than the present program does.

Senator SPECTER. Well, governmental services for lawyers are not inexpensive. The Department of Justice does not function at a low overhead hourly rate.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. I ran a district attorney's office which had a multi-billion dollar overhead, and office space which was very expensive, and it is not inexpensive.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. You talk about overhead. It does not take much to come to a figure that you talked about. You say your overhead is in excess of \$50.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. Well, perhaps Mr. Carter from the Public Defender Service can shed some light on what it cost on an overhead basis for a public office. So let us turn to him at this time, if we may.

Thank you very much.

Mr. ROSENTHAL. Senator, could I just make one more comment?

Senator SPECTER. Sure.

NO LEGITIMATE ANTITRUST ISSUE

Mr. ROSENTHAL. Coming back to your first question, about their testifying today in view of the antitrust threat that is hanging over their heads. I think it is important that they be free to tell their story, because when the story is told, I think it becomes clear that there is no legitimate antitrust issue here. So they have nothing to be afraid of.

Senator SPECTER. Well, I am concerned, Mr. Rosenthal, about where you have price fixing, and I asked you the question very seriously.

When a group of lawyers get together and agree to work for nothing, in a sense you can say that is price fixing. The figure is zero. There is an agreement.

Mr. ROSENTHAL. That is right.

Senator SPECTER. And maybe that is a restraint on trade, because other lawyers are now barred from earning some money, and if you have \$35 an hour, if you have lawyers who cannot compute their overhead, they may be working for nothing. They may be working for less than nothing.

Mr. ROSENTHAL. That is correct.

Senator SPECTER. And we have had the president and the vice president of the Trial Lawyers Association come to this hearing and they do not know what their overhead is.

Mr. Rosenthal. That is correct.

Senator SPECTER. And I am very much concerned about, very candidly, about the quality of legal service that you have here.

My practice in the criminal courts showed me that there are a lot of petitions for new trials for ineffective counsel.

Mr. ROSENTHAL. Most not granted.

Senator SPECTER. Most defense applications are not granted under any circumstance where there is very frequently great merit. That is the way the system works.

Mr. ROSENTHAL. That is right. There is one brute fact that makes this not price fixing, and that brute fact is that the City Council and the Mayor set the fee here. It cannot be price fixing by these lawyers when a government body sets the fee, that is why I am competent there is not culpable basis for criminal proceedings.

Senator SPECTER. You did not just expand the range of potential defendants?

Mr. Rosenthal. No, they are absolutely immune from antitrust prosecution.

Senator SPECTER. Are you sure?

Mr. ROSENTHAL. Well, in the antitrust area nothing is absolutely sure.

DISTRICT OF COLUMBIA

PUBLIC DEFENDER SERVICE

STATEMENT OF FRANCIS CARTER, DIRECTOR

APPEARANCE OF PUBLIC DEFENDER

Senator SPECTER. Let us turn now to Mr. Carter, if we may.

Mr. CARTER. You are the Director of the Public Defender Service?

Mr. CARTER. That is correct, Mr. Chairman.

Senator SPECTER. Could you give us an idea as to what your overhead is in the Public Defender Service, on an hourly basis, if you could refine it to that extent?

Mr. CARTER. I am not sure that question can be answered with any precision.

NUMBER AND SALARY OF LAWYERS

Senator SPECTER. How many lawyers do you have?

Mr. CARTER. Of 110 employees, there are 56 attorney positions.

Senator SPECTER. And what is the highest paid lawyer in your office?

Mr. CARTER. Is that line attorney, or I, as Director?

Senator SPECTER. Well, let us start with you, Mr. Carter.

Mr. CARTER. I receive a little over \$56,000.

Senator SPECTER. A little over \$56,000?

Mr. CARTER. That is correct.

LOCATION OF OFFICE

Senator SPECTER. And where are you officed; where do you have your office?

Mr. CARTER. We are in the basement of 451 Indiana Avenue, which is a court building.

Senator SPECTER. What do comparable offices cost on a yearly basis; square foot basis?

Mr. CARTER. We are there as tenants at sufferance and do not pay rent to the court system. The structure itself was built in the mid-1800's. I am advised that Francis Scott Key had his office there as U.S. Attorney.

Senator SPECTER. Well, it is a very valuable building, then. It is very high overhead.

Mr. CARTER. It is not in the K Street corridor. I would clearly have to make a guess, and that would probably be somewhere in the neighborhood of \$15 to \$20 a square foot.

NUMBER OF SECRETARIES

Senator SPECTER. How many secretaries do you have in your operation?

Mr. CARTER. Forgive me, I believe it is in the neighborhood of about 20. I can provide you later with exact figures.

[The information follows:]

The Public Defender Service has a total of 54 attorney positions in legal services (excludes only the Director and Deputy Director) for whom 12 secretaries work. Thus, the attorney-secretary ratio is 1:4.5.

Senator SPECTER. How many clerical people?

Mr. CARTER. That is the bulk of our clerical personnel. We have one photocopy operator and one messenger, and that is it, really. There are no paralegals.

ESTIMATION OF OVERHEAD COST

Senator SPECTER. Mr. Carter, I would be interested if you could undertake it to give me an idea as to what your overhead is on an hourly basis, by computing what would be a comparable rent, by computing your secretarial services, by the increment that you have which would be depreciated, by all the costs which would go into anybody figuring what overhead is. I would be interested to know that.

Mr. CARTER. I could make an attempt at that. I must say that on an hourly basis it is, of course, somewhat difficult, because we do not keep, as a private firm does, information on billable hours. Our attorneys spend as many hours as necessary to do their work, which includes, of course, evenings and weekends, as most attorneys involved with litigation must do. But I will make my best efforts in that, Mr. Chairman.

[The information follows:]

Overhead costs—Fiscal year 1983 figures

Personnel:

Agency administration	\$61,070
Support staff ¹	\$635,590
Subtotal	\$696,650
9.1 percent benefits	\$63,395
Other than personal services ²	\$494,000
Total	\$1,254,045
Fiscal year 1983 appropriation	\$3,588,900
Overhead of total (percent)	34.9

¹Includes portions of investigative and social services staff working for PDS attorneys and all secretarial and clerical staff.

²Includes such things as materials, supplies, law library, transcripts, and expert services used in defending cases. It does not include building rent because the Service does not pay rent and such costs are not included in the appropriation.

As the above chart indicates, approximately 35 percent of the Service's budget is used for overhead; that is, costs not directly associated with attorney salaries or the CJA program. A recent study, "1983 Economics Study of Private Law Firms," discussed in the September 27, 1983, Daily Washington Law Reporter, indicates that 1982 overhead for law firms was 37.2 percent of gross receipts.

USE OF BILLABLE HOURS

Senator SPECTER. You could take a figure on projecting billable hours to get some hourly rate. It is a variable. Many law firms shoot for 1,450 billable hours a year. Other lawyers, working by themselves, may work twice that many billable hours a year. It would be pretty hard to exceed 2,800 billable hours a year, because your lawyers have to spend time reading the advance sheets and continuing education, which is not a billable hour, and other administrative costs which are not billable time.

Mr. CARTER. In addition to a large number of volunteer hours to the system, either through court committees or bar associations.

Senator SPECTER. What is your judgment as to the figure of \$35 an hour for the lawyers who perform these services?

Mr. CARTER. For some time the agency has been in favor of an increase of the rates which, of course, were set and have been in place for over 10 years. Some personnel from the agency participated in a major study that was done in 1975 by a combination of the unified bar and the U.S. Court of Appeals, named for its chairmen, Austern-Reznek. That very comprehensive report, with respect to the representation of indigents in the local court system in 1975, recommended that the hourly rate should be raised to \$45 per hour. We have continued to push for that rate and believe that it is clearly appropriate, if nothing else, from the cost of inflation, from that time to the present.

Senator SPECTER. Mr. Carter, what does your No. 2 man earn?

Mr. CARTER. He earns \$50,000.

SALARY CAP OF CJA LAWYERS

Senator SPECTER. Are there, to your knowledge, any of those who work full time at the existing rates, who earn as much as \$56,000 a year, from the practice of handling these indigent cases?

Mr. CARTER. It is my understanding that the Superior Court, the Joint Committee on Judicial Administration, the governing body, composed of judges from both the Superior Court and the D.C. Court of Appeals which actually runs the plan for the appointment of counsel in the city, have put a ceiling of \$42,000 per annum on any attorney as the amount of money they can receive.

Senator SPECTER. That is gross?

Mr. CARTER. That is correct.

Senator SPECTER. Would somebody who earns \$42,000 be working pretty much full time?

Mr. CARTER. That would be my guess. It is my understanding—

Senator SPECTER. So there is no one who can work through that system who could be as well paid, as well as you are, or your first deputy?

Mr. CARTER. That is correct.

NUMBER OF PDS LAWYERS EARNING IN EXCESS OF \$40,000

Senator SPECTER. How many lawyers do you have in your office that earn in excess of \$42,000 or more?

Mr. CARTER. In addition to myself and the deputy, I believe there are only two other attorneys, one who is about to celebrate his 20th anniversary.

sary with the agency this year, and another one who has been with the agency some 15 years.

Senator SPECTER. Mr. Carter, thank you very much for your testimony. Very much appreciated.

Mr. CARTER. If you need other information, I would be happy to provide it.

Senator SPECTER. Well, I would be interested in the overhead figure.

When you talk about \$42,000 gross, however little overhead they have, they have to have some, so there would be a question—if you say their overhead is \$10,000 a year, that would be a net of \$32,000. How many lawyers do you have in your office who earn \$32,000 or more?

Mr. CARTER. There is probably a body of about 10 or so. That would be my estimation. Mr. Chairman, if I may comment on some of the things that has gone on before with respect to the system here in the District of Columbia, the concept the District has set up for its indigent defense, rightly or wrongly, depending upon one's view, is that our agency sits at the core of that. Our agency provides, cost-free, to both attorneys who accept indigent cases, as well as to the system, the Criminal Justice Act system, seven investigators who are full-time employees who do 85 percent of their work for appointed counsel.

Two of those employees who are on a full-time basis, train college students, at no cost to the system, who do the overflow investigative work for private counsel. That was referred to by Mr. Perrotta.

Our Offender Rehabilitation Division, Social Services Section, provides services not only to our own clients, but also to clients of court-appointed counsel, in seeking alternatives to incarceration.

The agency's library is free to all attorneys who accept court-appointed cases. Of course, we do not have the lexis or the computerized research system, but we do supplement it as much as we can with our own motions' file.

Senator SPECTER. Are you trying to get a lexis?

Mr. CARTER. It is my understanding that the prosecutors in the Office of the U.S. Attorney, as well as the Corporation Counsel, have had it for some years, and we will be talking with the District, possibly in fiscal 1985. But the cost is very great, and we have, at this point, supplemented our research, because we do not have paralegals, by utilizing our Appellate Division. We have file cabinets of our briefs by subject matter, as well as by title, and also a motions' file, from our—which our attorneys supply with their motions, that are available to the private bar, as they wish.

Senator SPECTER. I am sure that lexis could learn something from you. But there is nothing like using lexis, however good your files are.

Mr. CARTER. I would agree, Senator.

Senator SPECTER. Thank you very much.

Mr. CARTER. Thank you, Mr. Chairman.

NONDEPARTMENTAL WITNESS

DISTRICT OF COLUMBIA BAR ASSOCIATION

STATEMENT OF DAVID ISBELL, PRESIDENT

Senator SPECTER. Mr. Isbell, David Isbell, president of the District of Columbia Bar Association.

Mr. ISBELL. Senator, thank you for the opportunity to appear here today.

I think I do not need a Miranda warning. I have not been given any indication that I am one of the targets of the Federal Trade Commission investigation, and I trust I am not, although the D.C. bar has been firmly in support of the position of the Superior Court trial lawyers that the rate of CJA compensation should be increased.

Let me point out, if I may, that the D.C. bar has 40,000 members. It is a unified bar, established in 1972, a restriction early put upon the bar by a vote of its membership, was that it should not take positions on legislative matters without a vote on the particular position by the membership.

I believe that the membership has only twice voted on a particular legislative matter, and the position that the bar has taken on the matter of supporting an increase in the CJA compensation level, which was taken at a membership meeting in June 1982, is one of those two occasions. I think that is a measure of how important this issue is to the bar, as well as to the community.

I would like, if I may, Senator, to—it may be that you would prefer to proceed by asking me questions, but I have been listening to the testimony of the previous witnesses and I have made some notes about points that seem to me it might be worthwhile to add to what has been said.

Senator SPECTER. Please do.

Mr. ISBELL. If I may, let me do that. On the matter of overhead and pay rate and so forth, I have sat, and we are contemplating that you might be examining me on the specific figures applicable to my firm, but I have not been rendered too uncomfortable by that prospect, because the fact is I do not know what the figures are for my firm. If I did, my partners would be unbappy with my disclosing them, but as I said, I do not know.

I do, however, have some fairly confident impressions of the pertinent figures with regard to firms like mine and the legal community in general, and let me share those impressions with you. It may be that I would be able to get more concrete figures as to some of these matters, although I cannot promise that with a certainty.

OVERHEAD

As respects overhead, it is my impression that a fully staffed law firm will have an overhead that amounts to 50 to 60 percent of the gross revenues of the firm.

Put another way, if the average revenues of the firm come in at \$100 an hour for lawyer's time, which is about——

Senator SPECTER. Which is about an average, is it not, Mr. Isbell?

Mr. ISBELL. I would think that is within the ball park. That would mean that the overhead applicable to that \$100 was \$50 or \$60 per hour. I think that is probably a realistic figure.

PARALEGAL CHARGES

With regard to paralegal charges, I think they start at about \$35 and go up. That is the rates charged by law firms for the services of paralegals in this and comparable communities. I am not sure about the salaries; I think the salary rate is something like \$20,000 to \$30,000.

Associates, brand new lawyers, starting in the practice of law in a community like this in a fully staffed law firm, will command salaries of \$35,000 to \$40,000.

A figure that struck me as providing a particularly interesting prospective on this \$35 rate which is contemplated by the legislation which is now going through City Council, is the figure for court-awarded fees in suits in which the U.S. Government is a defendant. There has been a long, simmering—not simmering, flaming dispute between the U.S. Attorney's Office and the private bar, who are involved in making claims for attorneys' fees in suits which are defended by the U.S. Attorney's Office. That dispute has to do with a cap that the U.S. Attorney's Office seeks to impose on all claims for fees. That cap is \$65 an hour.

The private bar, by and large, is not accepting that cap and——

Senator SPECTER. What kind of cases are you talking about?

Mr. ISBELL. Civil cases; civil rights cases, and the like, cases where——

Senator SPECTER. Where the obligation devolves on the Federal Government to pay the attorneys' fees for the plaintiffs?

Mr. ISBELL. That is right.

Senator SPECTER. Mr. Isbell, there is another branch of calculation of compensation in the antitrust cases which have been celebrated recently where there is a multiplier effect which is frequently added.

Mr. ISBELL. Where you have got a private party paying the fee, and the fee is awarded, what you get is, you start with a load star, which is the normal billing rate, and then——

Senator SPECTER. What is the maximum billing rate that you know of for any private attorney?

Mr. ISBELL. Well, let me give you an idea of the normal billing rates which are shown by recent survey, law firm economics, conducted by the firm of Altman & Weil, Inc., showed in 1983 for cities like Washington, that the rate for experienced middle-level attorneys, 11 to 20 years of legal experience, was \$123 an hour.

Senator SPECTER. Do they have a maximum rate?

Mr. ISBELL. No, that is an average rate. And the average billing rate for junior attorneys with less than 2 years of experience was \$64 an hour.

Senator SPECTER. Well, is it not true that some attorneys bill at \$350 an hour?

Mr. ISBELL. Oh, yes, it is. Indeed, it is.

Senator SPECTER. And is it not also true that in some of the multiplier rates, in some of the antitrust litigation, that the courts have awarded counsel fees in the range of \$1,000 an hour?

Mr. ISBELL. Absolutely.

Senator SPECTER. Excuse me?

Mr. ISBELL. Absolutely, no question about it. But it seems to me that the \$65 an hour figure, which the U.S. Attorney's Office concedes is proper, resisting going any higher than, that that rate is particularly pertinent, because those fees are paid out of Government funds, and paid, in effect, by definition, for doing the public's work; that is, in effect, the premise of the award of fees in a suit in which the award of fees against the Government is provided by Federal statute.

There was another matter that I wanted to bring out, I think it may not have been made sufficiently clear on this record, which is that part of the agreement that was reached between the Superior Court Trial Lawyers and the D.C. Government—that is, the Mayor and the City Council—was that the \$35 rate is not going to be engraved in stone as the cap for all time.

In fact, it was part of the agreement that Chairman Clark and Councilwoman Rolark would introduce legislation promptly upon enactment of the pending legislation, to raise the rates further, to \$45 to \$55 an hour, and an effort will surely be made to bring about the enactment of that legislation at an early time.

I think, as a practical matter, it is not likely that that will get enacted so as to become effective as a budgetary matter within the fiscal year that is about to start. But it certainly is the hope and intention of all concerned that that legislation will be enacted at an early date.

I have pledged to bring the bar's support to that legislation by way of appointment of a special committee which will occupy itself in what I hope will be a more effective way than we have managed to occupy ourselves with this question until now, so as to bring that legislation to early fruition.

Senator SPECTER. Mr. Isbell, your testimony is very helpful.

What is your own personal assessment of the arrangement of \$35 an hour?

Mr. ISBELL. Well, it is a pittance. It is an improvement from what we had, but it is clearly insufficient. That is truly admitted all around. Everybody who has expressed a view on the matter has acknowledged that it is too small. It is merely a step in the right direction. The figures of \$45 and \$55 would be much more reasonable.

I suggest to you that the test ought to be that the rates be set at a level where there will be an economic inducement to people to enter

the field. If that were the case, if they were set at that level, then a strike, such as the one we have just seen, would not be effective.

The reason that the strike was effective, is that there is only a relatively small group of lawyers who are willing to take this kind of case. They are willing to take this kind of case at a substantial sacrifice to themselves, of performing an enormously important public service.

If that rate were higher, if the lawyers doing that work were unsatisfied with it, and went out, nonetheless the rate would suffice to provide an inducement for other lawyers to step in and fill the breach.

Senator SPECTER. Mr. Isbell, I would not articulate it quite that way, in terms of an inducement, but I would articulate it in terms of a fair compensation.

But I would suggest that those who are in this field, the D.C. Trial Lawyers Association, present the facts and figures to this committee, among others, which show what their cost of doing business are, and present a rational program as to what it costs you to do business, so that we can then see what your net return is and whether you are being paid reasonable compensation for the professional services which you are rendering.

That is a question of fairness to the attorneys who are supplying the service and that is also a question of adequacy of counsel to the people who are being represented, because I do not—I have a question in my mind as to whether you can have adequate representation from people who are grossly underpaid.

We have been through that in many contexts, for many, many years. That was the big cry in milk pricing. If the farmers were going to get too little to have sanitary milk conditions for milk, that is why you had to have minimum prices for milk, and it comes up everywhere.

The economic market forces ordinarily come into play so that you have the cost of production plus a reasonable profit to sustain the people.

But, for the testimony here today, we do not really have a picture of a rational pay approach from the people who are in this field.

The whole question of compensation of lawyers may be an appropriate subject of inquiry by the Committee on the Judiciary, and I am going to tell Chairman Thurmond of today's hearing. I serve on the Judiciary Committee as well, and it may be really useful to have an inquiry as to what is happening in other fields, what is happening in the antitrust field, which is within the purview of the Judiciary Committee, and how the lawyers' fees impact there.

Judge McGlynn of the U.S. District Court for the Eastern District of Pennsylvania recently handed down a very lengthy opinion scorching lawyers for the fees which were submitted. There was an opinion in the Texas Federal court which upheld very substantial awards recently, and those kinds of issues do have an impact on what it costs Americans to consume the goods which are involved in the economic process that leads to those antitrust issues, and there is some very material public concern about paying lawyers \$350 or \$500 or \$1,000 an hour. That is the other extreme.

But I have a question about whether you have price fixing if lawyers agree to work for nothing. And I am not sure what these lawyers have agreed to work for, on a net basis, when they charge gross \$35 an hour, and the Public Defender comes in and is earning more than private counsel and he is doing a comparable job in the defense of indigents.

But I appreciate the testimony which has been given here today, and this subcommittee is very much concerned about how the District of Columbia is going to pay these bills and what is going to happen if this settlement is upset, or if these lawyers are not available to perform these services at this rate of pay.

So, thank you all very much for coming.

SUBCOMMITTEE RECESS

The subcommittee will stand in recess subject to the call of the Chair.
[Whereupon, at 10:43 a.m. Tuesday, September 27, the subcommittee was recessed to reconvene at the call of the Chair.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

TUESDAY, NOVEMBER 1, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:08 a.m. in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

Also present: Tim Leeth and Bill Bowman.

DISTRICT OF COLUMBIA

BOARD OF PAROLE

STATEMENTS OF:

STANLEY HARRIS, U.S. ATTORNEY FOR THE DISTRICT OF COLUMBIA
BERNICE JUST, CHAIRMAN, DISTRICT OF COLUMBIA BOARD OF
PAROLE

ACCOMPANIED BY:

PATRICIA VALENTINE, VICTIM OF VIOLENT CRIME
RICHARD SIMMS, VICTIM OF VIOLENT CRIME
ED ROSS, U.S. ATTORNEY'S OFFICE FOR THE DISTRICT OF COLUMBIA
JOSEPH DiGENOVA, U.S. ATTORNEY'S OFFICE FOR THE DISTRICT OF
COLUMBIA
H. ALBION FERRELL, DISTRICT OF COLUMBIA BOARD OF PAROLE
JOHN GIBSON, DISTRICT OF COLUMBIA BOARD OF PAROLE
HALLEM WILLIAMS, CONSULTANT TO D.C. BOARD OF PAROLE
SHIRLEY WILSON, D.C. OFFICE OF CRIMINAL JUSTICE PLANS AND
ANALYSIS

Senator SPECTER. Good morning, ladies and gentlemen.

We will begin this hearing of the District of Columbia Subcommittee of the Appropriations Committee of the Senate. This hearing has been convened to fulfill our responsibilities on oversight concerning the District of Columbia Parole Board and is the second such hearing.

Without objection, my full statement will be introduced into the record at this time.

[The statement follows:]

STATEMENT OF SENATOR SPECTER

Good morning. Today is the second in a series of oversight hearings concerning the District of Columbia Parole Board. On July 20, 1983, we heard from the members of the Board and its distinguished chairman, Bernice Just, as well as from the U.S. Attorney, Stanley Harris. At that time, Mr. Harris expressed concern about the Board's policies on granting parole and parole revocation, and he raised disquieting questions about the recidivism rates of parolees.

Ms. Just kindly agreed to provide us with additional information on these subjects, and has done so. Some of the information we requested, I understand, is not available, but the Board is now expected to increase its data retrieval abilities with the creation of a new high-level position for research and data systems.

Certainly the Parole Board is an unsung and largely unseen major participant in our criminal justice system. More than any other judge, the Board decides which persons are to remain in prison and which are to be released. These are, of course, difficult decisions, because a wrong decision or too early a release might mean another innocent victim of violent crime. At the same time, prisons in D.C. and all over the country are bulging, and there is enormous competition for the scarce resource of prison space.

The statistics are sobering. A Parole Board study has shown a rearrest rate of 52 percent during the first 2 years of parole and an overall reconviction rate of 40 percent. Parole revocations dropped 22 percent in 1982 from 1981 totals. And although the numbers are down from previous years, almost 90 percent of those eligible are paroled at their first or second eligibility. Eligibility occurs after serving one-third of a sentence.

In addition, the Board, which has only three members, has increased its workload substantially in the past few years. I am greatly concerned that the Board have sufficient resources to do its job.

There are now several legislative proposals pending that would have a direct impact on the Parole Board. One, now before the Congress, would transfer from the U.S. Parole Commission to the D.C. Parole Board jurisdiction over parole of persons convicted in Superior Court but sentenced to Federal prisons. Another proposal before the City Council would reduce parole eligibility to 10 years (from 15 years) for those sentenced to life or a term greater than 30 years. A third would authorize early consideration of parole for everyone when prison crowding reaches a crisis point. We shall be interested to learn what policies the Board would employ if these proposals became law and new groups of inmates became eligible for parole. Also, these proposals would have an immediate impact on the Board's workload.

Along with Ms. Just, the chairman of the Parole Board, we are privileged to have here today Stanley S. Harris, U.S. Attorney for the District of Columbia, to discuss the prosecutor's perspective. In addition, John Kloch, the commonwealth's attorney for Alexandria, Va., and Andrew Sonner, State's attorney for Montgomery County, Md. They should help provide perspective into the workings of the parole system in those jurisdictions.

PURPOSE OF HEARING

Senator SPECTER. For the purpose of brevity and to expedite the hearing, in summary the committee is very much interested in doing what it can to expedite the administration of criminal justice in the District of Columbia, and toward that end, we have made certain substantial appropriations last year for additional judges, for additional U.S. attorneys, for additional prison space, for rehabilitation facilities, and a vital part of the entire criminal justice system turns upon the ability of the Parole Board to function and discharge its responsibilities.

Some of the overcrowding which we had heard about in the prisons is affected by the speed with which the Parole Board can discharge its duties, and there is a question which arose during the course of our hearings before about the adequacy of funding for the Parole Board itself, and the entire criminal justice system works as an interrelated whole.

We are not unmindful of the difficulties of making predictions when the Parole Board has to act because no one can be a guarantor of the public safety as to what will happen when any individual is released, and they are judgment calls in all respects. But I do believe that given the problems of public safety, it is an appropriate line of inquiry, and it is against that background that we convened this hearing today.

We seek only to determine what the facts are and how we might best pursue the administration of justice and public safety in the District of Columbia.

We will begin this morning with the Honorable Stanley Harris, U.S. Attorney for the District of Columbia, who is accompanied by Ms. Patricia Valentine and Mr. Richard Simms.

Judge Harris, we welcome you. You have been a judge; you are soon to be a judge again. We congratulate you formally as I just did informally on the submission by President Reagan yesterday of your nomination for the U.S. District Court for the District of Columbia.

You will soon come before the Judiciary Committee for confirmation hearings, a committee on which I sit, but I think it not inappropriate to say that the news account this morning accurately state that no difficulty is expected at your confirmation hearings, given your record of public service.

Mr. Harris, we welcome you here.

STATEMENT OF STANLEY HARRIS

Mr. HARRIS. Thank you for your kind remarks, Senator.

I have no prepared statement today. I have testified before you previously, expressing concerns about the operation of our parole system and the consequences which it has on the community.

Senator SPECTER. Judge Harris, let me interrupt just momentarily to welcome Mr. Joseph DiGenova and Mr. Ed Ross who are accompanying you here.

Mr. HARRIS. Thank you.

PRISON INMATE POPULATION

I might mention just very briefly, preliminarily, before answering whatever questions you might have, that I think a brief look should be taken at the District of Columbia prison inmate population. We, in our office, have a very active pretrial diversion program. We divert from the criminal justice process virtually anybody that we feel is divertable at an early stage.

After that, if people continue to become involved in the criminal justice system, probation typically is tried on two, perhaps three, occasions so that by the time you begin to get a prison population in the District of Columbia, that person is pretty much of a recidivist who has very likely started out with a juvenile record. As a matter of fact, the Bureau of Prisons considers the District of Columbia prison population to be the second most violent and dangerous prison population in the country, exceeded only by the people who came over in the Mariel boatlift.

Senator SPECTER. You say the second most dangerous prison population in the country?

Mr. HARRIS. Yes.

Senator SPECTER. What evidentiary base or what factual underpinning is there for such a statement?

Mr. HARRIS. I could not answer that. That was told to me by a Department of Corrections official as having been their conclusion, and I do not know the underpinning for it, except that it is a function of the fact that we do not sentence people to significant periods of incarceration unless and until they have demonstrated a violent period of recidivism.

Senator SPECTER. But the D.C. prison population, you say, is classified by a Federal correctional official as the second most violent and dangerous, only to you say the Mariel boat people?

Mr. HARRIS. Yes, sir.

PERIODS OF INCARCERATION

Now, beyond that, our next problem comes in a statute in the District of Columbia which requires that when a sentencing judge sentences somebody to a period of incarceration, the minimum period of incarceration must be no less or no greater than one-third of the maximum, so that if someone, for example, is sentenced to a 12-year period, possible 12-year period of incarceration, the minimum period of incarceration must be by statute 4 years.

Now, if you put that together with what I have referred to previously as a prison undercapacity in the District of Columbia, you have a situation in which, as I testified previously, 61 percent of the people who are incarcerated are released at their earliest parole hearing date, and 73 percent of the remainder are released at their second availability date. This results in almost 90 percent of the people who are incarcerated being released very, very early in their prison term, in other words, very shortly after the expiration of the minimum period of incarceration.

Now, we do have a chronic offender unit in the office. In 1983, now, our chronic offender unit, Senator, concentrates on people who have been charged with crimes of violence while they are on release for prior crimes of violence, and release either on their personal recognizance, on parole or probation, and the rather striking statistic, but not surprising statistic, is that in 1983 our chronic offender unit in the first 10 months of the year has dealt with 404 defendants. Of those, 47 percent were on parole; that is, 190 of the 404 were people who were on parole for a crime of violence at the time of being charged with a new crime of violence.

Now, there are two things which I would like to submit for the record. I will not take the time to go through them here, but I think they would be useful to the committee.

Senator SPECTER. You say those are chronic offenders, 404?

Mr. HARRIS. That is the term we use, people that go into our so-called chronic offender unit. They are people who are charged afresh with a crime of violence while on release for a prior crime of violence.

Senator SPECTER. Mr. Harris, do you have any statistic for the number who are on parole for all of those who are rearrested?

Mr. HARRIS. We do not have that available, sir, but we could, through our computer system, respond to that question.

Senator SPECTER. All right. I would be interested in that if you can provide that to us without undue difficulty.

PREPARED STATEMENT

Mr. HARRIS. The two things which I would like to provide for the record, the first is a statement which I made to the District of Columbia Council in opposition to several bills which would make parole even easier to obtain at an early date for people who were incarcerated. That particular statement, which deals with three District of Columbia proposed pieces of legislation, dated October 3, 1983, does present, I think, a rather full overview of the types of problem in which you are interested.

Senator SPECTER. Without objection, that will be received into the record.

[The statement follows:]

STATEMENT OF STANLEY S. HARRIS, U.S. ATTORNEY FOR THE
DISTRICT OF COLUMBIA

This written statement is submitted to explain in some detail my reasons for testifying in opposition to the passage of Bill 5-16, the Parole Act of 1983; Bill 5-244, the Prison Overcrowding Emergency Powers Act of 1983; and Bill 5-245, the District of Columbia Sentencing Improvements Act of 1983.

Let me begin by stressing what I consider to be one of the key roles of the United States Attorney as the prosecutor of adult crimes in the District of Columbia. There is in our city an organization, financed by the taxpayers, called the Public Defender Service. It is a fine organization, performing a needed service. However, its name is somewhat misleading, for it does not represent the public. Rather, it represents a relatively small percentage of the criminal defendants in our city -- typically, as a matter of fact, recidivists. The public -- that is, the law-abiding citizens who must be protected against the criminal element in our midst and who all too often become victims of crime -- must be and is represented by the prosecutors of the United States Attorney's Office.

Perhaps the best way to make my initial point is to quote from an article on the editorial page of the Wall Street Journal which was written nearly a year ago about criminal trials. The author of that article, Vermont Royster, stated in relevant part as follows:

What has happened to the law, I think, is a forgetfulness that there are two parties in every criminal trial. One is the accused, a real person easily visible. The other is "the state," a seemingly impersonal and institutional entity. An injustice to the individual is readily understood. Injustice to "the state" is not so readily recognized. To many, including lawyers, a "fair trial" has come to mean only fair to the accused; fairness to the other party is forgotten.

Yet that entity "the state" is not only all of us but each of us. The person called the prosecutor is in fact a public defender. His task is to try to make our homes and streets safer by removing from society those who 12 ordinary citizens decide have been guilty of injury to one or more members of society.

My 182 Assistant United States Attorneys and I fully endorse those observations. So that, as my sons would say, is where I am coming from today. I am here with pre-eminent concern for the victims of crime -- past, present, and future.

I do not like saying what I feel obliged to say today. I would like to speak glowingly of law enforcement successes. I would like to say that our so-called correctional institutions have a meaningful number of people in them who are there needlessly and who are ready to become productive members of

society. I cannot do so. The unfortunate but inescapable truth is that we have not too many in our prison facilities but too few.

In giving this testimony, it is our purpose to recite considerable statistical information which, while imperfect, does present a striking overview of what is happening in our criminal justice process. In doing so, I express appreciation to the Department of Corrections for making considerable information available to us for analysis.

I must advise you of my personal, and my Office's institutional, conviction that the problem that the District of Columbia currently is facing is not one of "prison overcrowding," but one of "prison undercapacity." The facts are that those who are incarcerated should be incarcerated, the citizens of this community justifiably desire that they remain incarcerated, and prison expansion is the only proper solution to the problem. This Council would not be acting responsibly if it legislated to achieve the premature release of repeat and dangerous offenders into the law-abiding community by passing the three Bills that are the subject of this hearing.

The appropriateness of characterizing the problem as one of "prison undercapacity" becomes clear when one takes a close look at those who are incarcerated and the reasons for their confinement. Dangerous and repeat offenders permeate our prison population. Statistics generated by the Department of Corrections confirm that fact. The average sentence being served by inmates committed to Lorton Reformatory in 1982 was substantial: that average was 2-3/4 years to 11-1/2 years. During the first quarter of 1983, the average sentence of those committed to Lorton jumped to from 4-1/2 years to just over 14 years. Further, in 1982, approximately 32% of the inmates were sentenced to consecutive terms of imprisonment, an additional 21% of the inmates were serving concurrent time on multiple counts, and approximately 16% of the inmates had detainers pending against them for other crimes charged in this or other jurisdictions. Data on the past criminal history of inmates unfortunately is not kept by the Department of Corrections, but experience dictates, and the above figures confirm, that virtually all of those incarcerated at Lorton are recidivists.

That the inmates at Lorton are dangerous is clear from the types of crimes for which they are incarcerated. In 1982, 45.6% of the newly-committed inmates were incarcerated for crimes against persons, and during the first quarter of 1983 that figure jumped to 52%. Armed robbers comprised 56.9% of those incarcerated for personal crimes in 1982; during the first three months of 1983 they comprised 67% of the same population. Persons convicted of drug abuse, burglars, thieves, and weapons offenders, in that order, accounted for an additional 46% of the total prison population. The remaining prisoners were incarcerated for other offenses, which include bail jumping and escape. When the intimate connection between drug and weapons offenses and other crimes is factored into these figures, the serious and violent nature of virtually all of the inmates cannot be disputed.

The above statistics represent defendants committed to Lorton for the first time for a particular offense. Convicts who were recommitted to Lorton for parole violations, halfway house and work release violations, and escapes, represented approximately 40% of inmate admissions. This fact serves to verify that those incarcerated should remain there as ordered by conscientious judges for the good of the community and for the safety of potential innocent victims.

I recognize that a number of offenders affected by the Bills before this Council currently are incarcerated at Occoquan, a small step admirably taken to help relieve overcrowding at Lorton. Although intended to house only misdemeanor convicts, Occoquan also holds convicted felons. In 1982, 83.3% of the Occoquan residents had been convicted of assault, grand theft, weapons, drug, and other serious offenses. Bail violators, parole violators, and fugitives accounted for an additional 2.5% of the population. Of those inmates at Occoquan, 75.4% previously had been committed to the Department of Corrections, and 35% were there on drug convictions. Thus, it is only sensible to conclude that most of those at Occoquan are serious offenders. Moreover, experience reveals that all of the committed offenders are recidivists, for the alternatives of pretrial diversion, the Federal Youth Corrections Act, and probation literally without exception have been exhausted before a Court has determined that incarceration is the appropriate remedy to achieve the inescapable goals of deterrence and punishment.

The D.C. Jail also houses many sentenced offenders who would be affected by passage of the Bills before the Council. Sentenced felons comprise over 25%, and sentenced misdemeanants comprise only 11%, of the current population of the jail. Most of these are awaiting transfer to Occoquan or Lorton, and the available information reveals that many are serious -- and virtually all are repeat -- offenders. Further, the vast majority are drug abusers. A recent Washington Post article indicated that as many as 76% of the inmates at the D.C. Jail were drug abusers (during a time in which the City was not cracking down in any concentrated way on drug offenders).

One point cannot be overemphasized. When prison needs were projected two or three decades ago, not even the wildest pessimist could have predicted the extraordinary extent to which narcotics and narcotics-related offenses would swell both our incidence of criminal offenses and our prison populations. Today, the intimate connection between drug abuse and other serious criminal activity is well established. Recent studies have shown that large numbers of incarcerated offenders were under the influence of drugs when they committed their crimes, and that heroin addicts -- of which the District of Columbia has far more than its share -- commit six times as many crimes during periods of addiction as during periods of abstinence. Thus it is deplorable but not surprising that 80% of the offenders committed to the Lorton Youth Center admit to having abused drugs. This very serious problem should be addressed by the Council, but prematurely turning convicted abusers out on the streets is not a tolerable solution.

The extent to which incarcerated persons already are being returned to society at an early date should be recognized. In 1982, the Board of Parole released 61% of all prisoners at their first hearing dates, and 73% of the re-

mainder were released at their second hearing dates. As might be expected, in a recent study by the Board of Parole which was designed to evaluate the success or failure of prisoners released to parole supervision, the authors found that 52% of parolees incurred new arrests during the two-year period following their release.*/ Eighty percent of those rearrested subsequently were convicted. Of additional interest is the further finding that of those who sustained convictions while on parole, more than one-half never had their parole revoked, and remained on the streets of this community pending their new convictions. Thus, an unacceptably high number of offenders who are on parole are continuing to victimize law-abiding citizens, and to add to their number by prematurely releasing others would only exacerbate the situation.

In light of all of the above, it is evident that our jail and prisons house dangerous and repeat offenders, many of whom maintain dangerous drug habits, and almost all of whom must remain incarcerated with their normal release dates if anything more than lip service is to be paid to ensuring community safety.

Next, it is important to emphasize that the citizens of this City, who comprise the Council's and my own constituency, want serious offenders to remain incarcerated. Their concerns were made clear by their overwhelming approval of the Mandatory Minimum Sentences Initiative which became law last June. They also have supported recent police efforts to apprehend repeat and serious offenders, and are participating in growing numbers in neighborhood crime watch programs. The Council would be showing disdain for these efforts if it enacted the proposed Bills.

Further, much public and private effort and money have been expended in order to identify, apprehend, and convict serious offenders. This investment of time and money should not be wasted by releasing those offenders prematurely. Such a result would be inconsistent with the popular view that violent and dangerous offenders should be incarcerated, as evidenced also by the strong support shown for the bail law amendments which were passed unanimously by this Council 15 months ago.

Given this expressed concern, it should be no surprise that the citizens would be willing to foot the bill to keep dangerous recidivists off the streets. As do you, we have frequent contacts with citizens and community leaders. It is our conclusion that they virtually unanimously support the appropriation of public funds to increase jail capacity. I would willingly join with the Council in posing the issue directly to the citizens of this City, and I would live (happily, I am confident) with the results. Moreover, such expenditures ultimately would be returned to the City many times over if the streets were made safer for businesses on which to operate and for individuals to enjoy.

*/ Of those, 25% were rearrested between 1 to 4 months of parole, 56% were rearrested within 8 months of their parole, 79% were rearrested within a year, and only 21% lasted at least 13 months without being rearrested.

Additionally, to release criminals prematurely is to buck the current local and national trend to treat crime victims, both actual and potential, with more compassion. The majority of released criminals currently victimize others shortly after their release; their premature release thus would create proportionately more victims. Not only is this result unacceptable to the reasonable person; it is contrary to the expressed intent of this Council in proposing and passing several victims rights bill, two of which are scheduled to be heard in two weeks, on October 17, 1983.

In sum, any measure which would result in the premature release of serious offenders would make a mockery of citizen efforts to improve the safety of their community, would be inconsistent with other actions taken by this Council, and would contradict common sense.

It is thus clear that the problem of prison undercapacity can be solved only by building or acquiring more prison space, and this is a solution that not only is attainable, but that is directly supported by the Congress of the United States, which only last week appropriated more than \$20 million for added prison facilities. In the recent past, due to the growing crime rate, the criminal justice system has been supplied with additional judges, additional prosecutors, additional support personnel, and additional court facilities. Despite those facts, little additional prison space has been provided to house the additional criminals which inevitably have been caught, prosecuted, and incarcerated. This situation cries out for correction.

It should be noted that our jail is crowded with inmates who properly should be in a prison facility. Data developed by the Department of Corrections reveals that in 1982, an average of 482 inmates, or 25.1% of the total jail population, were sentenced felons. An additional average of 212 prisoners, or 11.1% of the total jail population, were sentenced misdemeanants. These inmates should have been sent to a correctional, instead of to a detention, facility. If that had occurred, the jail (by its own figures) would have been underpopulated. We believe that this situation remains unchanged in 1983.

Further, it is significant to note that, contrary to the belief of some, the jail is not full of pretrial detainees. Jail authorities unfortunately do not keep precise statistics, but a substantial number of the unsentenced offenders actually have been convicted but remain in jail awaiting sentence. Therefore, the percentage of unsentenced offenders who are detained awaiting trial should be very small -- probably less than 10% of all defendants awaiting trial. Moreover, under the current bail laws, almost all of those are violent, dangerous, and/or repeat offenders.

Some have suggested that because recent crime statistics seem to indicate that reported crime has decreased slightly, no new measures need be taken to expand prison capacity. Initially, I would point out that the figures reflect only the reported crime rate, and it is commonly accepted that 50 to 70% of the crime in any large urban area goes unreported. Beginning, however, with the reported crime rate, the Metro-

politan Police Department's own statistics reveal that in 1982 they "closed," by identifying the assailant, only 57.5% of the murders, 64.3% of the forcible rapes, 20.8% of the robberies, 65.6% of the aggravated assaults, and 13.2% of the burglaries which were committed and reported. These numbers do not reflect accurately the percentage of criminals actually caught, however, because the Police Department considers a case "closed" if only one of several perpetrators is identified, and in a significant number of cases, identification does not correlate with arrest. In sheer numbers, the Police Department reported that in 1982 it "closed" 127 out of 221 reported murders, 285 out of 443 reported rapes, 2,040 out of 9,799 reported robberies, 2,332 out of 3,553 aggravated assaults, and 2,071 out of 15,682 reported burglaries.

Of the 221 reported homicides, only 61 guilty judgments were entered, with 33 cases remaining open. Thus, in less than 30% of the reported homicides was the murderer ever held accountable for his actions. Further, of the 443 reported rape offenses, only 76 guilty findings were obtained. Of the frightening total of 9,799 reported robberies, only 706 defendants were held accountable. For the offense of aggravated assault, only 182 defendants were found guilty out of 3,553 reported cases, and for the offense of burglary, only 419 guilty judgments were entered out of a total of 15,682 reported cases. Moreover, it is unquestionably true that a large percentage of those convicted received probation, and that less than half of them went to jail. In short, of the total number of persons who commit crimes in this City, only 20 to 50% have their criminal activities reported, only 10 to 20% are identified, less than 5% are convicted, and less than 3% are incarcerated. Thus, it is clear that of the large number of serious offenders in this City, only an infinitesimal percentage actually are incarcerated for their crimes. To strive artificially through legislative fiat to reduce this number manifestly is absurd, for that percentage is, in my view, an irreducible minimum.

Also illustrative of the continuing serious nature of the crime problem in this City are the increases in the reported incidents of armed robbery, robbery, and drug offenses. Over the last five years the number of adults arrested for armed robbery increased from 721 in 1978 to 896 in 1981, with the 1982 statistics showing a slight decline to 805. The number of adult arrests for unarmed robberies increased steadily from 849 in 1978 to 1,097 in 1981, with the 1982 figures showing a slight decrease to 1,014. For felony drug offenses, the numbers have risen steadily from 169 arrests in 1978 to 2,353 in 1982. An additional 4,641 misdemeanor drug arrests were made in 1982.

Insofar as the number of cases indicted may provide a more accurate forecast of the future prison population, the statistics for the key offenses of armed robbery and drug abuse are both informative and staggering. In 1978, 372 defendants were indicted for armed robbery, and 124 defendants were indicted for drug offenses. In 1982, 561 defendants were indicted for armed robbery, and 863 defendants were indicted for drug offenses.

It is therefore evident that any slight decrease in the amount of reported dangerous and violent crime in this City will have no long-term effect on the prison population,

and should not be used as an excuse to ignore the problem of prison undercapacity. Similarly, discussions of alternative sentencing and diversion beg the issue. Alternative sentencing is a tool which currently is frequently used by judges in appropriate cases, and our Office already is exercising pre-trial diversion for virtually every eligible defendant. Further, as stated above, most, if not all, of those sentenced to incarceration previously have been granted forms of diversion and probation. (Literally the only exception to the sequential diversion and probation route prior to incarceration is the first-degree murderer, who may have no prior record but who faces a mandatory sentence of 20 years to life.)

Focusing specifically on the three Bills before the Council today, I must urge the Council to defeat each one. The "Parole Act of 1983," Bill 5-16, introduced by Councilmember Ray, proposes to release exactly those violent and dangerous criminals who should remain incarcerated for a more substantial period of time by reducing the minimum period of detention to 10 years. Those inmates who are incarcerated for more than a minimum of 10 years are murderers, rapists, and armed offenders. This Bill would advance most of their release dates by at least four to five years, and, as statistics prove that the majority of those released will victimize others relatively soon after release, passage of the Bill would pose a clear and present danger to the community.

Moreover, I am obliged to point out that technically the Bill may not accomplish what it supposedly is intended to achieve. The preamble to the Bill states that it intends "to require that all prisoners become eligible for release on parole after having served ten years" (emphasis added), but, in our view, it would not apply to first-degree murder convictions. 22 D.C. Code § 2404(b) states that "notwithstanding any other provision of law," a person convicted of first-degree murder must serve a minimum of 20 years. Additionally, it is questionable whether the Bill's terms would apply to prisoners serving consecutive sentences totaling more than 10 years. (We believe that they would not.) Of course, I am not advocating that this Bill be amended to include persons convicted of premeditated first-degree murder or to prisoners serving substantial consecutive sentences, but rather that it be defeated in its entirety.

Concerning the "Prison Overcrowding Emergency Power Act of 1983," Bill 5-244, also introduced by Councilmember Ray, I note that it would allow the Mayor, as a means of budget control, to release dangerous prisoners into the community. Reduced to its essence, this Bill would sacrifice the safety of the community on the altar of fiscal irresponsibility.

There are other problems inherent in the Bill which should cause it to fail of passage. The Bill provides for repeated acts of reducing sentences by 90 days, even for persons who have no chance of being released immediately as a result. For those prisoners who are not within 90 days of parole eligibility, who indeed may be eight to ten years away from parole eligibility, the existence of an undefined "emergency" would result in reducing their ultimate sentences for no good reason, and would not assist in solving the immediate problem of reducing prison congestion.

The third piece of legislation under consideration, the "District of Columbia Sentencing Improvements Act of 1983," Bill 5-245, introduced by Councilmember Rolark, is unwise and probably illegal. In extending the time for granting a motion to reduce sentence from 120 days to one year, following what ultimately could be a denial of a petition for a writ of certiorari to the Supreme Court years after conviction, this Bill would make a mockery of the time-honored concept of certainty in sentencing, and would undermine the very purpose of deterrence that underlies the act of sentencing. The Supreme Court has spoken clearly about the need for finality in all legal, and especially criminal, proceedings, most recently in deciding death penalty cases. If this Bill passes, defendants will be on notice that the criminal justice system in the District of Columbia may be manipulated to exact minimal punishment, and the deterrent effect of other actions taken by this Council will deteriorate.

Additionally, this Bill would tie up scarce judicial resources at late stages of criminal proceedings, and would detract from recent efforts to afford defendants not yet convicted more speedy trials. I doubt that the Council seriously desires this result.

Moreover, a motion to reduce sentence is not designed to be used as a tool to reduce the number of criminals incarcerated. The caselaw is clear that a motion to reduce sentence properly is to be filed only to allow a court to reconsider its sentencing decision in light of the factors present at the time of sentencing, and not in light of a prisoner's artificial conduct in the early stages of his incarceration. An offender's conduct in prison properly is a subject of consideration by the parole board, and not by the sentencing judge.

Finally, and decisively, this Bill erroneously assumes that the Council has the power to amend the Superior Court Rules which govern the filing of sentence reduction motions. Section 946 of Title 11 of the D.C. Code states that the Federal Rules of Criminal Procedure shall apply in Superior Court except as otherwise authorized by the District of Columbia Court of Appeals. The Home Rule Act provides that the Council of the District of Columbia may not alter Title 11. District of Columbia Self-Government and Governmental Reorganization Act, D.C. Code, Title VI, § 602(a)(4). Therefore, any amendment to the Superior Court Rules requires action by the judges themselves, and any legislation by the Council on this matter would be inappropriate. Nonetheless, I note that the Federal Criminal Rule 35 has been amended to allow greater flexibility, and our courts now are studying the situation.

All three of these Bills thus are based upon the wrong premise -- that convicted serious offenders should be released prematurely for budgetary reasons -- rather than on the correct premise that convicted serious offenders, who at great expense to this City have been apprehended and prosecuted, should be treated and kept in a secure facility for as long as the sentencing judges found appropriate and necessary. Hard statistics prove that premature release results in creating untold numbers of new victims, and to accept this result would be to ignore the citizens' mandate to make their

streets, homes, and businesses as safe as possible. It is time for the District of Columbia government to recognize both the realities of the situation and the will of its constituents, to bite the proverbial bullet, and to provide more facilities to solve the problem of prison undercapacity. As I have noted, that task was aided by the fact that just last week, the Congress of the United States appropriated more than \$20 million for that purpose. Maximum effective use should be made of those funds, and the Council -- as should the Executive Branch -- should deal realistically with the existing problems.

It does not please me to bring to light the realities of our relative lack of law enforcement success in today's world, in which the cancer of narcotics and narcotics-related crime is eating away at the very fabric of our social institutions. I would serve this distinguished body poorly, however, were I to do otherwise. It is axiomatic that a large amount of crime today is committed by a disproportionately small number of chronic offenders. Once such offenders have been brought to justice, it defies reason to support their premature release for purely budgetary reasons. No one can be unaware of the dramatic increase in recent years of dead-bolt locks, alarm systems, and barred windows and doors. It is the law-abiding citizens of the Nation's Capital, rather than its criminal element, who deserve the full support of the Council.

CASE FINDINGS

Mr. HARRIS. Second, we felt that it would be useful to pick a few examples of the commission of violent crime by people who are on parole and put together those particular defendants' prior criminal records, their parole dates, and the offenses which they committed while on parole. We have that information with respect to seven defendants, and I think that the committee would find that particularly interesting.

Senator SPECTER. Could you summarize those case findings, Mr. Harris, if any pattern emerges through them?

Mr. HARRIS. Well, the pattern that emerges in each of these is a person with a serious criminal record who has been paroled shortly after the earliest possible time, the minimum portion of the sentence which they were serving for serious crime, and then again committed, in some of these cases committed multiple, major, violent criminal acts, including murder.

Senator SPECTER. Start with the one at the top of your list and let's deal with that for a moment. What is the charge for which the person was paroled?

Mr. HARRIS. I'm sorry. I missed the question.

Senator SPECTER. Why don't we start with the name of the defendant.

CASE OF NORMAN COLEMAN

Mr. HARRIS. All right. The first defendant is Norman Coleman.

Senator SPECTER. And Mr. Coleman was charged with what offense?

Mr. HARRIS. He was charged with rape and first-degree burglary, having been committed on September 17, 1982. The jury found him guilty of assault with attempt to rape and first-degree burglary. His prior

record included assault, for which he received 3 years' probation, a rape which was committed in April 1976, for which he was sentenced under the Youth Corrections Act, 18 U.S.C. 5010(c), to a 15-year maximum.

Now, the Parole Board takes the position—and I think I am confident that they are correct technically—but in effect there is basically no real minimum under a 5010(c) commitment, but the fact is that he was paroled roughly 2½ years after he was committed.

Later he was involved in a narcotics sale in the District of Columbia for which he received 180 days. He was convicted of a third-degree sex offense in Maryland, received a 5-year sentence for that. In March 1981, the parole which he had received on his prior District of Columbia rape case was revoked, and then 16 months later, he was paroled again.

In this particular case—

Senator SPECTER. I don't follow this record. It says in March 1981 parole revoked on D.C. rape. What does that mean, Mr. Harris?

Mr. HARRIS. Well, the second item listed there in his prior record, a rape which he committed in April 1976.

Senator SPECTER. I see.

Mr. HARRIS. He was paroled from that incarceration in December 1978, and then later when he had another sex offense in Maryland, his District of Columbia parole for that 1976 rape charge was revoked.

Senator SPECTER. Oh, it says that he had 5 years on the third-degree sex offense in Maryland. The inference may be here that he served time in Maryland until the revocation of his parole in the District of Columbia in March 1981?

Mr. HARRIS. I don't know the answer to that. Let me see if one of my assistants does.

Mr. DiGENOVA. What was the specific question, Senator?

Senator SPECTER. I'm trying to draw an inference as to what happened here.

Mr. HARRIS. He did serve time in Maryland, I am told. How long, I do not know.

Mr. DiGENOVA. This demonstrates, Mr. Chairman, the time lag that frequently exists between the conviction for a serious crime and revocation. I think what may be giving the Chair pause is that if you will notice, the D.C. offense which is the narcotics sale in 1979 is the last D.C. offense prior to the revocation, and then there is an intermediate Maryland offense, and then it is only subsequent to that, in March 1981, which follows the parole granting in 1978, that the revocation occurred.

Senator SPECTER. Well, I'm trying to figure it out, Mr. diGenova. There were 6 weeks which elapsed between the narcotics sale in Washington, D.C., and the Maryland sex offense. So that might be insufficient time for revocation, but it was not until March 1981 that the D.C. revocation on parole occurred, and it may be that he was in custody in Maryland until that time. We just do not know from this record.

All right; I get the point. And he was paroled then in July 1982 and September the same year he was charged with this rape. Was he convicted on this rape charge on September 17, 1982?

Mr. HARRIS. Yes, he was. He was chased from the scene of the crime by a group of teenagers who were attracted by the screams of the victim.

Senator SPECTER. And he was caught on the spot?

Mr. HARRIS. Yes.

Senator SPECTER. Let's take a look at one more case, Mr. Harris.

CASE OF MELVIN WYNN

Mr. HARRIS. I think it might be useful if we turned to the case of Melvin Wynn. I do not know if they were put together in the same way, but it is the third one in my pile.

Senator SPECTER. Yes, I have it here.

Mr. HARRIS. Now, in the space of 1 month, from August 2 until September 2, 1982, he robbed four different Safeway grocery stores at gunpoint. He confessed to committing them.

Regarding the third offense on August 28, 1982, Mr. Wynn and another man entered the Safeway on Michigan Avenue NE, held his gun on clerks and customers as the second man removed money from the registers. The final offense on September 2, Mr. Wynn and a second man entered the Safeway on Naylor Road. Here he pointed his gun while his companion took money from the cash registers. An off-duty Federal Protective Service officer, Sgt. Richard Simms, saw what was happening and warned people to get on the floor. He notified an off-duty Metropolitan Police Officer in an effort to stop the crime. There was a struggle and Officer Simms was shot by this defendant, very nearly lost his life. We have Officer Simms here today, and I think that it would be very interesting to have him recount briefly his feelings about being the victim of a crime.

I would stress the point, Senator, that in this particular case, the defendant was on parole for a second-degree burglary. He had been sentenced to 2 to 6 years and he was released at his initial hearing, and then committed these offenses.

TESTIMONY OF SERGEANT SIMMS

Senator SPECTER. Officer Simms, would you step forward, please? Would you state your full name for the record, please?

Sergeant SIMMS. Richard A. Simms.

Senator SPECTER. Would you tell us, Sergeant Simms, what happened to you in this situation?

Sergeant SIMMS. I was at the Safeway store on Naylor Road and Alabama Avenue on September 2, picking up some groceries when I noticed two men barge in the door of the cashier's office. At that time I warned all of the customers in the store to get down on the floor, that a robbery was in progress.

I knew that one of the cashiers there was an off-duty Metropolitan Police Sergeant, so I informed him, at which time I went outside to call and get him some assistance. When I came back to the store, to the front of the store, Mr. Wynn was holding a meatcutter hostage at gunpoint, the gun pointed at his side.

A struggle ensued with Mr. Wynn, myself, and the meatcutter to free the hostage, at which time Mr. Wynn started to run, ran a couple of steps, turned and fired his weapon, striking me in the chest. It collapsed my left lung, broke two ribs. Fragments of the bullet were embedded in my heart.

Senator SPECTER. Fragments of the bullet were in your heart?

Sergeant SIMMS. Yes, sir; they still are. They did not remove them. When it hit the bone, the bullet broke up and fragments penetrated the muscle in my heart.

Senator SPECTER. Did you draw your service revolver?

Sergeant SIMMS. I am not permitted to carry my service revolver off duty, sir.

Senator SPECTER. You were off duty at the time?

Sergeant SIMMS. Yes, sir.

Senator SPECTER. I see. What happened next?

Sergeant SIMMS. A struggle ensued. The defendant and I fell over a rail, at which time when my lung collapsed, I just passed out and the defendant got away. I should say one of the defendants got away. The other one was captured in the store.

Senator SPECTER. So you were off duty at the time, and you saw the robbery in process, and you intervened?

Sergeant SIMMS. Yes, sir.

Senator SPECTER. How long have you been on the police force?

Sergeant SIMMS. Seventeen years, sir.

Senator SPECTER. Seventeen years?

Sergeant SIMMS. Yes, sir.

Senator SPECTER. How old are you?

Sergeant SIMMS. Forty-one.

Senator SPECTER. You look younger than 41, Sergeant.

Now, the regulations of the Washington, D.C., Police Department prohibit you from carrying your service revolver?

Sergeant SIMMS. I'm not with the D.C. police force, sir; I'm with the Federal Protective Service under the General Services Administration.

Senator SPECTER. I see. Is that your Federal Protection uniform that you are wearing at the present moment?

Sergeant SIMMS. Yes, sir.

Senator SPECTER. During the course of your work for the Federal Protection Service, do you carry a revolver?

Sergeant SIMMS. Yes, sir, .38 Smith & Wesson, 4-inch barrel.

Senator SPECTER. Have you taken a look at the record of Mr. Melvin C. Wynn?

Sergeant SIMMS. I have seen parts of it, sir, yes, sir.

Senator SPECTER. What is your judgment as to the parole in this case, Sergeant?

Sergeant SIMMS. Would you repeat the question, please?

Senator SPECTER. Do you have a judgment or feeling as to the fact that Mr. Wynn was put on parole, given his record here?

Sergeant SIMMS. I do not think it is right. No, I do not.

Senator SPECTER. OK. Thank you very much, Sergeant Simms.

Sergeant SIMMS. Yes, sir.

PREPARED STATEMENT

Senator SPECTER. We very much appreciate your being with us. We have received your written statement and it will appear at this point in the record.

[The statement follows:]

STATEMENT OF RICHARD SIMMS

I am a Sergeant with the Federal Protective Service, where I have been employed for 19 years. On September 2, 1982, I was shopping at the Safeway Grocery Store on Naylor Road S.E., Washington, D.C. As I was walking toward the store office, a customer told me the store was being robbed. I told all the cashiers and customers to get down, then I told Sgt. Mitchell, an off duty Metropolitan Policeman, what was happening. The two robbers came out of the office and Sgt. Mitchell yelled "Halt, Police," then shot once but hit neither. I went outside to call 911, the police emergency number and I saw that Sgt. Mitchell was backing out of the door. The man who shot me, who I later identified as Melvin Wynn, came out holding a hostage, the meat cutter. The hostage grabbed Wynn's gun and struggled until he broke free from Mr. Wynn. I chased Mr. Wynn but he turned and fired at me hitting me in the chest. I later identified Mr. Wynn at a lineup as the man who shot me. I was seriously wounded: both lungs collapsed, part of the bullet hit my heart, and cannot be removed, and two ribs were broken. I was hospitalized for two weeks and did not return to work for a month.

Defendant:	Melvin C. Wynn	DOB: 6/17/60	23 years old
Offense:	Armed Robbery - Safeway on Rhode Island Avenue, N.E., Washington, D.C.		
Offense Date:	August 2, 1982		
2nd Offense:	Armed Robbery - Safeway on Michigan Avenue, N.E., Washington, D.C.		
Offense Date:	August 21, 1982		
3rd Offense:	Armed Robbery - Safeway on Michigan Avenue, N.E., Washington, D.C.		
Offense Date:	August 28, 1982		
4th Offense:	Armed Robbery - Safeway on Naylor Road, S.E., Washington, D.C.		
Offense Date:	September 2, 1983		
Arrest Date:	October 14, 1982; Parole Warrant issued at Government's request.		
Disposition Date:	February 9, 1983		
Disposition/Sentence:	Defendant pled guilty to two counts of Armed Robbery and one count of Assault with a Dangerous Weapon; he received an aggregate sentence of ten to thirty years.		

Prior Record:	1978	Bail Reform Act Violation (D.C.)	Probation
	1979	Larceny (North Carolina)	
	3/3/80	Second Degree Burglary (D.C.)	Two to Six years
		Paroled at initial hearing	Paroled 9/29/81

Facts:

In the space of one month from August 2 until September 2, 1982 Melvin Wynn robbed four different Safeway Grocery Stores at gunpoint. He confessed to committing these crimes at the time of his arrest. Regarding the third offense, on August 28, 1982, Mr. Wynn and another man entered the Safeway on Michigan Avenue, N.E. Wynn held his gun on clerks and customers as the second man removed money from the registers.

In the final offense, on September 2, Mr. Wynn and a second man entered the Safeway on Naylor Road, S.E. Again, Mr. Wynn pointed his gun while the second took money from the registers. An off-duty Federal Protective Service officer, Sgt. Richard Simms saw what was happening and warned people to get on the floor. He notified an off-duty Metropolitan Police Officer what was happening so that officer shot at Wynn but did not hit him. Wynn grabbed a meatcutter as a hostage. They struggled and Wynn broke away and ran, but changed his mind, turned and fired once at Simms who was chasing him. He hit Simms in the chest nearly killing him. Wynn was arrested on October 14, 1982.

Parole Information:

The defendant committed these robberies only ten months after being paroled for a burglary conviction in the District of Columbia. He was paroled at the earliest time possible under the law and parole guidelines.

CASE OF NATHANIEL WASHINGTON

Mr. HARRIS. One other defendant to whom I would like to refer is Nathaniel Washington. Nathaniel Washington was convicted in November 1978 of armed robbery and was sentenced under the Federal Youth Corrections Act. He was paroled, his parole was revoked, and then he was reparaoled in August 1982.

The offenses with which we are familiar and, of course, we do not, needless to say, apprehend every offender each time they commit an offense, but in this particular case, this parolee committed three offenses; that is, two armed burglaries and two armed robberies in a 3-week period only 8 months after he had been paroled for another armed robbery.

Now, Patricia Valentine, who is one of Mr. Washington's victims, also is here this morning, Senator, to tell you what happened to her, if you would like to hear from her.

Senator SPECTER. Yes, please, I would.

Ms. Valentine, please step forward.

Mr. Harris, before Ms. Valentine testifies, the prior record was for armed robbery on November 14, 1978, and there was a sentence under 18 U.S.C. 5010(b) for a maximum 6-year sentence, paroled on September 15, 1980. The parole was revoked on October 26, 1981.

Do you know why, Mr. Harris, his parole was revoked at that time?

Mr. HARRIS. I just asked Mr. Ross that, and I do not know. I do not know whether Mr. Kracroff knows.

Senator SPECTER. And then he was reparaoled on August 17, 1982. This defendant had one conviction for armed robbery. How old was Nathaniel Washington at the time he committed the first armed robbery on November 14, 1978, if you know?

Mr. HARRIS. We do not have his date of birth on this particular sheet or his age, but certainly he was 22 or less, under 22 at the time that he was committed under the Youth Corrections Act.

His parole was revoked for technical violations. He did not keep a job; he did not report, and so he did not comply with the conditions of his parole.

TESTIMONY OF PATRICIA VALENTINE

Senator SPECTER. Ms. Valentine, thank you for joining us here. What happened to you, if anything, as a result of conduct of Mr. Nathaniel Washington?

Ms. VALENTINE. On May 9, around 11 a.m., I was to report——

Senator SPECTER. Would you speak up just a little bit, please?

Ms. VALENTINE. OK. On May 9, 1983, around 11 o'clock, I was due to work around 3:30, and so I was at home. I heard a knock on the door.

Senator SPECTER. You were asleep at about 3:30 in the afternoon?

Ms. VALENTINE. No. Around 11 o'clock, I heard a knock on the door, and I went to open the door, and this is when Nathaniel Washington forced his way in with a gun in my face. When he got inside, he took my right arm and twisted it behind me and forced me on back toward the bedrooms. My daughter was in the first bedroom. We stopped right in front of the bedroom. He threatened me to stand still and threatened her to be quiet and stay put.

Then he forced me on back into my bedroom and he shoved me on the bed. He starts searching the dresser drawers and snatched my jewelry off my neck. He took my jewelry from the dresser and a watch from my nightstand.

At the same time he kept asking me was there any other valuables in the house. I was so frightened I could not say nothing. So at that time he stood in front of me and was leaving out my bedroom door, and he told me if I was to call the police or move, that someone was watching the house and that he would kill my daughter. So he shut the door, and at the same time my phone is usually down by my bedside. So I used the phone and I dialed the police.

The police came right away, and somehow Mr. Washington got away at that particular time. I gave the statement to the arresting officer, and they took the statement.

About 4 or 5 hours later that evening—I did not go to work. I had to be at work at 3:30, but behind that, I was so upset I could not attend—so we were outside talking to a few neighbors to see if they saw anything. At the same time, Mr. Washington and two other young men walked down my parking lot, and I recognized the guy right off, and I questioned my neighbors to see if they had recognized the guy or knew him. They did not. So I told my husband, and he had one of the guys

to go into the apartment next to mine to ask the young man to come out.

So they stayed in about 2 minutes. So we both went over to the door, and the guy came out, and he never said—you know, he never denied it or anything. So the neighbors helped out a lot. They held him there until I went in and called the police, and they arrested him.

Senator SPECTER. And you testified to that effect, and he was convicted?

Ms. VALENTINE. Yes. He admitted to the crime.

PREPARED STATEMENT

Senator SPECTER. Thank you for your testimony, Ms. Valentine. In addition to your oral presentation, we will make your formal statement a part of the hearing record.

[The statement follows:]

STATEMENT OF PATRICIA VALENTINE

I am employed at Electronic Data Systems as a computer operator. On May 9, 1983, I was working the 3 p.m. to 11 p.m. shift. At 11:30 a.m., I was in my apartment in Southeast, Washington, D.C. with my three year old daughter when I heard a knock on my door. I answered the door being careful to open it only slightly. However, a man pushed the door open, pointed a gun at me, twisted my arm and forced me back into my bedroom. My daughter came out of her room and said, "Don't hurt my momma," so the man yelled at her. The man grabbed two gold chains from my neck, then went through my dresser and took a watch. He shut me into my bedroom and ran out of the apartment. I made an immediate report to the police. That evening, I saw this same man outside my apartment building. Some friends stopped the man, and I called the police. The police arrived quickly and arrested the man I identified, Nathaniel Washington.

Defendant:	Nathaniel Washington		
1st Offense:	First Degree Burglary While Armed, Armed Robbery		
Date Offense:	April 20, 1983		
2nd Offense:	Armed Robbery		
Date Offense:	May 2, 1983		
3rd Offense:	First Degree Burglary While Armed, Armed Robbery		
Date Offense:	May 9, 1983		
Date Disposition:	October 5, 1983		
Outcome:	Defendant pled guilty to two charges of Armed Robbery, and has not yet been sentenced.		
Prior Record:	11/14/78	Armed Robbery	18 U.S.C. 5010(b) Federal Youth Correction Act Maximum Six Year Sentence
		Paroled	9/15/80
		Parole Revoked	10/26/81
		Re-Paroled	8/17/82

Facts: First Offense

On April 20, 1983, Anthony Gross, a seventeen year old high school student was leaving his apartment at 9:00 a.m. to go to school. As he opened the door, Mr. Washington and two other men were waiting. Washington had a pistol and forced Mr. Gross back into his apartment where he was bound and gagged. Washington and his cohorts stole a television and stereo equipment before fleeing. Mr. Gross positively identified Mr. Washington at a lineup.

Second Offense

At 2:30 a.m. on May 2, 1983, Kenneth Quattebaum was parking his cousin's Cadillac on Third Street, N.W. As he was locking the door, Mr. Washington walked up, pointed a gun at him, took his money and keys before escaping in the Cadillac. The car was found several hours later and was missing its wheels. Quattebaum positively identified Mr. Washington as his assailant at a lineup.

Third Offense

At 11:30 a.m. on May 9, 1983, Patricia Valentine answered a knock on her door. When she opened the door, Nathaniel Washington forced the door open, tore chains from her neck, searched her drawers, then shut her in her bedroom with her daughter. Later that day, Miss. Valentine saw Mr. Washington again in her neighborhood. She reported this to the police and he was arrested.

Parole Information

Nathaniel Washington committed two armed burglaries and two armed robberies in a three week period only eight months after he had been paroled for another armed robbery.

Patricia Valentine, one of Mr. Washington's victim's is here today to tell you what he did to her.

FACTS OF ARMED ROBBERY UNKNOWN

Senator SPECTER. Mr. Harris, in taking a look at the case involving Nathaniel Washington, the issue which confronts the Parole Board is what to do with a man who apparently has been convicted as a juvenile under the Federal Youth Correction Act for armed robbery. We do not know what the facts of that armed robbery were from this record. He has a maximum 6-year sentence, and then he is paroled in September 1980. The parole is revoked in October 1981 for technical reasons you say, and reparaoled in August 1982.

What is your professional judgment, if you can make a judgment based on what we have before us, as to the degree of danger that a man like Mr. Washington poses to the community as of August 17, 1982?

Mr. HARRIS. I suffer from the same information gap to which you correctly allude. Certainly the Parole Board is faced with difficult decisions. What we basically are doing here is pointing out that overall we have, in my view, an unacceptably high rate of recidivism among parolees who demonstrably have been paroled at an early date, and these cases simply are intended to flush out illustrations of them, but there is inadequate information here on which you could make a subjective judgment as to a particular time of release.

Senator SPECTER. Well, when you deal with the statistics, about 47 percent, I believe you testified, of the chronic offenders having been on parole, that certainly is a statistic which supports your conclusion about premature release.

When you take a look at the record of Nathaniel Washington, with one armed robbery for which you do not know the facts, which we do not know the facts on this record, it is not easy to make a judgment that the Parole Board was wrong.

Mr. HARRIS. That is correct.

RECORD OF MELVIN WYNN

Senator SPECTER. If you take a look at the case of Melvin Wynn, about whom Sergeant Simms testified, there you have a string of horrible armed robberies, a whole series. There is no question about that, and in his record you have 1978 Bail Reform Act violation, D.C. proba-

tion. We do not know what that means, and I take it you do not either on the basis of this record here.

Mr. HARRIS. That would indicate a failure to appear for a court appearance.

Senator SPECTER. All right. In 1979, larceny, North Carolina. It is unclear what the import of that is, and then in March 1980, a second-degree burglary in the District of Columbia, 2 to 6 years, paroled at initial hearing.

I take it your point is that that is inappropriate. Would you say that was an inappropriate release, to be paroled at the initial hearing, given the two prior incidents on Mr. Wynn's record?

Mr. HARRIS. I have inadequate information on which to base that type of a conclusion. Basically we are illustrating here that this man, after being paroled, in a period shortly thereafter or sometime thereafter, became sort of a one-man crime wave.

Senator SPECTER. That certainly is true. The issue more narrowly focused is whether the Parole Board exercised appropriate discretion in releasing him when they did in March 1980, judged by the facts available to them at that time. Would you have a judgment on that, Mr. Harris?

Mr. HARRIS. I'm sorry, sir?

Senator SPECTER. I say, would you have a judgment based on the information at hand as to whether you disagree with the Parole Board's conclusion to release Mr. Wynn in March 1980?

Mr. HARRIS. Well, one of the factors which is missing here is whether the particular person was involved with the use of heroin. We have a very significant percentage of our chronic offenders who are addicted to heroin and who support their habits.

Senator SPECTER. I do not see any indication on this record that he used heroin.

Mr. HARRIS. Well, I say we do not have anything in our information here, and that so often is a critical factor, and one which I cannot comment on here. I do not know whether it is present or not.

RAND CORP.'S SURVEY OF CALIFORNIA INMATES

I might comment briefly on the Rand Corp.'s survey of California inmates. They studied many inmates in California and they found in a group of them who were addicted to heroin, those convicts admitted to committing an average of 34 robberies, 58 burglaries, and 22 thefts per person per year. That is a total of 114 offenses per year which were admitted to by heroin addicts.

We have a very significant percentage of our incarcerated population who have problems with drugs. I do not know where any of these people would fit in that.

Senator SPECTER. Taking a look at the case of Mr. Norman Coleman where he was paroled in July 1982, there, at least on the surface of the record, there is quite a prior record, which would raise a question as to the appropriateness of the action of the Parole Board.

Would you have a judgment on that case as to whether you would agree or disagree with the Parole Board's actions, Mr. Harris?

Mr. HARRIS. Well, I share Mr. DiGenova's concern about the length of time which passed before the parole was revoked. With respect to the next parole——

Senator SPECTER. That is the critical one. The critical parole is July 1982.

Mr. HARRIS. Again, we do not have the type of information that the Parole Board has or that the sentencing judge had at the time of sentencing so that the basic data which would be needed to make a subjective judgment is not present for us.

Senator SPECTER. You are not prepared to make a judgment on that specific case either?

Mr. HARRIS. Correct.

JUDGMENT AS TO PAROLE BOARD RELEASES

Senator SPECTER. Do you have an overall judgment as to the appropriateness of the releases by the Parole Board?

Mr. HARRIS. The overall judgment is that too many people are being released too early who prove that which the sentencing judge believed when ordering a period of incarceration, and that is that they are dangerous to the community.

Senator SPECTER. Thank you very much, Mr. Harris. Is there anything you would care to add? Your testimony is very helpful.

Mr. HARRIS. No. Thank you very much, sir.

Senator SPECTER. We very much appreciate your being here.

[CLERK'S NOTE; The following case histories were submitted for the record:]

CASE HISTORIES

Defendant: Norman Coleman DOB: 10-6-55 28 years old

Offense: Rape, First Degree Burglary

Date of Offense: September 17, 1982

Date Trial: July, 1983

Outcome/Sentence: Jury Verdict of guilty of Assault with Intent to Rape, and First Degree Burglary; defendant sentenced to serve 15 to 45 years

Prior Record: 7/ 7/75 Assault (D.C.) 3 Years Probation

4/14/76 Rape (D.C.) 18 U.S.C. § 5010(c)
15 year maximum
Paroled 12/22/78

9/27/79 Narcotic Sale 180 days
(D.C.)

11/8/79 Third Degree Sex Five years
Offense - (Maryland)

3/81 Parole Revoked on D.C. Rape

7/82 Defendant Paroled

Facts:

On September 17, 1982, at 9 p.m., Mamie Joyner left her home in Southeast Washington to walk to the corner market. En route, the defendant grabbed Miss Joyner around the neck, pulled her into an alley and beat her in the face. He forced her to the ground, raised her skirt, removed her underwear and then forced her to have sexual intercourse against her will. Miss Joyner was then able to break away. Several male teenagers had heard the victim yelling so chased the defendant till he broke into an apartment. The police were summoned and the defendant was arrested. Miss Joyner identified the defendant that very night.

Parole Information:

The defendant was paroled in 1978 after serving only 2 1/2 years on a D.C. rape conviction. He was convicted of a drug sale in the District of Columbia in 1979, and of a sex offense in Maryland. In March, 1981 his parole was revoked in the District of Columbia to be re-paroled in July, 1982. Only two months later, Mr. Coleman raped Mamie Joyner.

Defendant: Timothy Washington

Offense: Armed Robbery, Assault with Intent to Kill
while Armed, Carrying a Dangerous Weapon

Date of Offense: September 26, 1982

Date Trial/
Disposition: March, 1983

Outcome/Sentence: Jury Verdict of guilty on all counts; seven
to twenty-one years

Prior Record: July, 1978 Rape 18 U.S.C. § 5010(c)
Assault with Intent 15 year maximum
to Commit Sodomy Paroled December
1981

Robbery
(D.C. Offense)

Facts:

At about 1 a.m. on September 26, 1982, Kathryn Liles drove her car to Potomac Gardens, an apartment complex in Southeast Washington. There she met the defendant, Timothy Washington. Although she had never met him before, they spoke for about an hour and a half. She agreed to give Mr. Washington a ride. At the end, he unexpectedly punched her in the face repeatedly. Miss Lyles escaped from her car with Mr. Washington chasing her. He caught her, stabbed her several times in the chest and breasts, and took her pocketbook before he fled. She was hospitalized for a week recovering from her wounds. Subsequently, Miss Lyles identified Mr. Washington at a lineup.

Parole Information:

The defendant committed this offense only ten months after being paroled for a conviction for rape, assault with intent to commit sodomy and robbery. He had served only three years out of a fifteen year sentence when paroled.

Defendant:	Colon C. Flood	
Offense:	Assault with Intent to Rape, Assault with Intent to Commit Carnal Knowledge, Taking indecent Liberties with a Minor Child, Enticing a Minor Child	
Date Offense:	March 8, 1983	
Date Arrest:	March 15, 1983	
Date Trial/Disposition:	August 2, 1983	
Outcome/Sentence:	Defendant pled guilty to Assault with intent to Rape and Enticing a Minor Child; he was sentenced to serve 18 months to twelve years	
Prior Record:	1973 Manslaughter (D.C.)	4 - 12 years 6/27/77 to 6/9/85 (initial eligibility 6/9/77)
	1978 Grand Larceny Two Counts (Fairfax, Va.)	2 - 12 months (D.C. Parole not Revoked)
	1981 Carrying A Dangerous Weapon (Knife)	One year Probation 11/10/81 - 11/9/82 (Parole not revoked as result of conviction)
	1981 Rape Arrest	Acquitted 9/15/82

Facts:

Mr. Flood lived in the same building with the twelve year old female he sexually assaulted. On March 8, 1983, Mr. Flood had the victim come to his apartment early in the morning before school. He asked her to do some dishes and she agreed. She was about to leave for school when Mr. Flood grabbed her, and carried her to his bedroom. He laid her down on his bed on her back. Mr. Flood held her by the throat, and warned her not to make any noise as he removed her pants and underwear. Fortunately, Mr. Flood's estranged wife entered the apartment at that time and the assault was ended.

Parole Information:

Mr. Flood was paroled in 1977 having served four years for manslaughter. Despite a 1978 Grand Larceny conviction in Fairfax, Virginia, his parole was not revoked in the District of Columbia. Moreover, he was convicted of Carrying a Dangerous Weapon in 1981 and his parole was not revoked.

Defendant: James R. Burroughs DOB: 3/3/41 42 years old
 Offense: Armed Robbery
 Date Offense: July 5, 1982
 Date Trial: February 15, 1983
 Outcome/Sentence: Jury Verdict of Guilty; Sentenced to 10 - 30 years
 Prior Record: 1970 Petit Larceny 120 Days (D.C.)
 1971 Armed Robbery 10 to 30 years
 Assault with Dangerous Weapon (D.C.) Paroled 3-30-81
 3/22/82 Distribution of PCP Two years probation

Facts:

James Burroughs and his co-defendant robbed a High's Dairy Store on July 5, 1982. Mr. Burroughs acted as a lookout while his associate pointed a sawed-off rifle at the sales clerk and took \$37 from the cash register. Mr. Burroughs twice blocked a special police officer from entering during the robbery, then ran from the store after the gunman escaped. Both were caught within minutes and identified by the witnesses.

Parole Information:

The defendant was paroled in 1981 after serving the minimum ten years for his 1971 armed robbery and assault with a dangerous weapon conviction. His parole was not revoked when he was convicted of distribution of drugs in 1982. He committed this armed robbery in July, 1982, four months after conviction for a drug offense, and seventeen months after he was placed on parole.

Defendant: Gaither D. Moore
 1st Offense: Armed Robbery of Giant Food
 Date of Offense: January 13, 1982
 2nd Offense: First Degree Felony Murder While Armed, Armed Robbery, Carrying a Pistol without a License - McDonald's holdup
 Date of Offense: January 19, 1982
 Date of Disposition: January 17, 1983
 Disposition/Sentence: Defendant pled guilty to Armed Robbery in the Giant Food offense (1st offense above) and to Second Degree Murder and Armed Robbery in the McDonald's case. Defendant received an aggregate sentence of thirty years to life imprisonment.
 Prior Record: 3/15/77 Manslaughter while Armed (D.C. offense) 18 U.S.C. § 5010(c) Federal Youth Corrections Act
 15 year maximum sentence
 Defendant paroled on 9/11/80, to be on parole until 1991

Facts:

Giant Food Robbery

At midnight on January 13, 1982, Gaither Moore entered a Giant Food Store on Minnesota Avenue, N.E., brandishing a sawed-off shotgun. Two co-conspirators, Michael and Robert Corum, had pistols and robbed three cashiers. Meanwhile, Mr. Moore forced the security guard to the floor and stole his .38 caliber service revolver.

McDonald's Robbery and Murder

At 11 p.m. on January 19, 1982, Gaither Moore and Robert Corum approached the counter at the McDonald's Restaurant on Burroughs Avenue, N.E. Moore drew the pistol he stole at the Giant Store, announced a robbery, then walked directly up to the security guard, Michael Crennell. Without hesitation he shot him once between the eyes killing him instantly. Crennell was defenseless; he had not even taken his own service revolver out of his holster when he was killed. Moore took this weapon from Crennell's body after he fell. Moore unsuccessfully tried to get the safe open while Robert Corum pointed his sawed-off shotgun at the cashiers and stole over \$500. The two fled to Michael Corum's waiting car. They were caught by the Metropolitan Police within five minutes, and recovered were all the proceeds and weapons. Moore was returned to McDonald's where he was identified.

Parole Information:

Gaither Moore was convicted of manslaughter while armed in 1977. He received a maximum sentence of fifteen years, and was paroled after serving three and a half years on September 11, 1980. Within sixteen months of his parole date, Mr. Moore had killed another person and robbed many others.

STATEMENT OF BERNICE JUST

APPEARANCE OF PAROLE BOARD

Senator SPECTER. I would like now for Chairman Bernice Just, Rev. H. Albion Ferrell, and John Gibson to step forward, if you would, please.

Ms. JUST. Mr. Specter, I have asked Ms. Shirley Wilson, who is the Director of the Office of Criminal Justice Plans and Analysis, and Mr. Hallem Williams, who is serving as a consultant to the Board, to join me at the table.

Senator SPECTER. That is fine. They are certainly welcome here, Chairman Just.

RECIDIVISM STUDY

Chairman Just, your study of recidivism among parolees involves some 332 persons between 1977 and 1979, and according to the information provided to me, you found that 52 percent of that group was re-arrested within 2 years, and 40 percent convicted of a new crime. In light of this recidivism rate, do you plan to have a study with a larger sample?

Ms. JUST. Yes, we do. The Board is engaged at the present time in a risk assessment study, using a research tool that has been developed out in the State of Iowa. Our Board is participating in this study under a funding arrangement between the U.S. Justice Department's Bureau of Justice Statistics and the D.C. Office of Criminal Justice Plans and Analysis. Ms. Wilson, who is administering that grant and the study, can speak to that.

Senator SPECTER. Ms. Wilson.

Ms. WILSON. We are looking at 1,283 parole cases.

Senator SPECTER. Over how long a period of time?

Ms. WILSON. These are all of the persons who were granted parole in calendar year 1980, and essentially what we are doing is looking at—

Senator SPECTER. You say those are the entire group of people granted parole?

Ms. WILSON. Yes. Essentially what we are doing is looking at a number of factors that have been proven as accurate predictors in Iowa of the potential for further involvement in serious crimes of violent crime.

Senator SPECTER. What was that about Iowa? I am sorry; I did not understand.

IOWA RISK ASSESSMENT

Ms. WILSON. This risk assessment tool was developed in Iowa by Dr. Daryl Fisher. He looked at a number of variables, about 19 primary variables and about 5 additional ones, and did a massive study on the parole and probation populations in that State. He looked at these various factors and determined which ones could predict further criminal involvement.

The primary predictors are: Juvenile record, arrest on the instant offense, age at time of arrest, marital status, most of the factors that one would assume would be good predictors of further involvement in crime.

What Dr. Fisher did was develop a scale of the probability that the person would be involved ranging from ultra high risk to low risk.

COMPLETION OF STUDY

Senator SPECTER. Ms. Wilson, when do you expect that study to be completed?

Ms. WILSON. I expect it to be completed in June 1984. We are doing a partial validation of the Iowa risk assessment by looking at all of the parolees for the year 1980. We are looking at the same variables that Dr. Fisher used.

The only difference in our study and what was done in Iowa is that we are excluding probation cases. We feel that once that tool has been developed for the District, we will have more objective factors available to us to determine whether or not a person poses a serious risk at the time of the parole hearing.

Senator SPECTER. When will that partial study be completed?

Ms. WILSON. Well, when I say partial validation, that is the full study. That will be done in June 1984.

CHANGING PRACTICES OF PAROLE BOARD

Senator SPECTER. Chairman Just, do you have any plans to vary in any way the practices of the Parole Board between now and June 1984?

Ms. JUST. No, we do not. We are using guidelines which were developed in the last part of 1980-81, and we are taking advantage of this study that is being done now to also compare the application of our guidelines.

Senator SPECTER. June 1984 is some 8 months away before you will have the findings, and it will take some period of time to implement beyond that date. What is your response or reaction to what the U.S. Attorney Harris had to say about the Parole Board's activities?

Ms. JUST. I am sorry, in the first place, that we were not aware of the cases that Mr. Harris planned to bring or, in fact, that he planned to bring any cases to you this morning. If so, I would be in a better position to comment on them.

But let me say this, that under the Youth Corrections Act, the thrust of a commitment is to meet the rehabilitative needs of the individual, and these needs have been assessed by a professional team of classification people, including psychologists, vocational specialists, educators, and social workers.

The purpose of the Youth Corrections Act is to commit a youth to, in our case, the Lorton Youth Center, to address those needs that have been identified by the diagnostic team and are considered to be contributive to the commission of crime.

When the programs that the Lorton Youth Centers offer have been completed, the Board then makes an assessment as to whether the rehabilitative goals have been met and will grant parole at that time. Under the 5010(b) commitment there is a mandatory release in 4 years.

Under 5010(c) the commitment is interminable. Commitments can be for 15 years or even longer. What that means is that the person is subject to parole supervision for that length of time, but the critical question is whether the person can continue to benefit from the programs offered at the Lorton Youth Centers.

Just recently this question has come up in the courts, and I am not familiar with the citation, but somewhere in the land a determination has been made that if the youth center can say to the court that we see no basis for further benefit to be gained by this individual, then it is possible to have that person, upon revocation, sent to an adult facility. But right now a person who, let's say, is age 35 serving under a 5010(c) commitment, and his parole is revoked, then he must return to the youth center where just by the fact of age there is no further benefit.

[CLERK'S NOTE: The citation was supplied for the record. It is *Watts v. Hadden*, 651 F.2d 1354 (1981).

RELEASE OF YOUTH

Senator SPECTER. Chairman Just, let me see if I understand you. You have referred a couple of times to a point where there is no further benefit to the youth to continue that commitment, but what about the protection of society for that youth to be retained in custody?

Ms. JUST. That is a valid question, but the way the law is constructed, the person has to be committed for his own benefit.

I am going to ask Mr. Ferrell to speak further to that because he has much more familiarity with that.

Senator SPECTER. You are saying that it is your understanding that at the point that there is no further benefit to the youth, that he is to be released without any concern for the safety of the community?

Ms. JUST. That is my understanding, but I will ask Mr. Ferrell to speak to that.

REMARKS OF REVEREND FERRELL

Mr. FERRELL. I do not know how to respond, sir. I think the first thing to understand is that the Parole Board has a responsibility for young people committed under the Youth Act when those people are certified to the Board as having made significant progress under the Youth Act, to very seriously consider paroling those people.

You may recall there was a case of Heidi Fletcher some number of years ago. Ms. Fletcher was involved in a robbery of some kind. I do not recall exactly what it was because it was not our case. She was sentenced under the Youth Corrections Act and sent to a facility in California. The U.S. Parole Board, as it was at that time, because of the nature of the offense, and it captured headlines here, and without regard to what was reported to be her progress in the institution, said that because of the seriousness of the crime and their assessment of risk and that sort of thing, that they would not grant her parole.

This matter came before the courts, and the United States—I do not remember the judge, but one of the judges in the U.S. District Court for the District of Columbia ruled at that time that under the Youth Act, if she had showed significant progress, that the nature of the offense and whatnot were not to be held against her, and she was granted parole.

Now, the Board labors under that difficulty.

My own view, very frankly, Senator, and I have said this before other committees and commissions of the Congress of the United States, is that in my opinion the Youth Act is not appropriate for certain kinds of offenses: armed robberies, homicides, rapes. In my opinion, the Youth Act is not an appropriate designation for that.

If, however, the court, in its wisdom, chooses to apply the Youth Act, then it seems to me that the Board has its responsibilities.

Now, let me say one or two other things, Senator. I am trying to think of the exact legal terms that are used, something about—in the complying of its discretion—capriciousness and what is the other word that goes along with that?

Senator SPECTER. Arbitrary?

Mr. FERRELL. Arbitrary and capricious. To avoid the risk of being arbitrary and capricious, the Board has developed its criteria for granting parole, I believe, which have been furnished to you.

In addition to the matter of previous criminal activity, and in addition to the nature of the present offense, there are other factors which the Board takes into consideration. You said earlier that you had secured additional appropriations for the Department of Corrections to apply in an effort to improve the mental, educational, whatever other conditions of inmates in our various institutions.

When those inmates come before us, they bring with them a prison record, not of our making, but attested to by the institutional staff, that during this period of time the person has been incarcerated he has been involved in this program, this program, this program, this program, and so on down the line.

Now, the Board has to make, along with other considerations that it makes, has to make an assessment as to the worthwhileness, first of all, of the programs the person has been involved in, the worthwhileness of the programs themselves and second, a determination as to what benefit the person has received from those programs, and whether these things taken together have some effect on what the young man brought with him.

Now, very frankly, these are difficult decisions, and if I may be permitted an emotional response which perhaps I should not make, often as I listen to the radio there is a guy who sings "Take This Job and Shove It." One wonders at times whether or not one is involved in a worthwhile activity as to whether or not the making of parole decisions, which by their very nature you cannot please everybody; it is just impossible, nor do I intend to try to please everybody.

So let me say, too, you have presented other victims of crime today. I sit here as a victim of crime. Two weeks before last Christmas on two separate occasions within a 7-day period my house was burglarized, actually burglarized, and a third attempt was made.

PREMATURE RELEASE OF CRIMINALS

Senator SPECTER. Reverend Ferrell, do you disagree with what Mr. Harris has testified to today about the premature release by the Parole Board of criminals?

Mr. FERRELL. I cannot say that. I cannot say that I do. Let me say one other thing, and take this for whatever answer it is worth.

Yes, I am disturbed that, to use the figures, 47 percent or whatever they are, of the people whom we parole return to crime within a reasonably short period. I am disturbed about that. We talk about statistics. Senator, when we are at a parole hearing, we do not have a statistic sitting in front of us. We have a person.

Now, if those statistics said that 100 percent or 90 percent of the people involved in armed robbery would return to armed robbery, then you have got a clear, a reasonably clear and certain predictions that you can make. But when it says that one out of two or one out of three, and you have someone sitting before you, how do you know on which side of the line that person falls? And shall you because of that fact, shall you say then that because one of two may fail, then nobody goes?

Senator SPECTER. Reverend Ferrell and Chairman Just, I would appreciate it if you would be willing to take a look at these three specific cases we talked about today, to get your judgment, if you are willing to do that, so that you can give us your evaluation.

But let me return to a matter of substantial concern to me. Chairman Just has said that in dealing with the youthful offenders—and these cases do not all involve youth offenders—that is only one aspect. Some of them do not, but when Chairman Just says that they are to be released if there is no further benefit to the individual youth, then I say how about the question of safety to the society, and then she defers to you, Reverend Ferrell, and you say that the standard is whether the youth has shown significant progress.

SAFETY OF THE COMMUNITY

Mr. FERRELL. Well, let me follow up on that.

Senator SPECTER. Just a minute. Let me ask you the question. Where is the standard about the safety of the community? There is more to the Youth Act than simply the standard, as Chairman Just says, about no further benefit to the individual, and more to the Youth Act than the citation you make about showing significant progress. There is a factor on parole as to the safety of the community as well.

Are you saying, Reverend Ferrell, that that is not a consideration?

Mr. FERRELL. No, no. I did not say that, Senator. I did not say that. My own view is that if the young man has not progressed to the point that he is no longer a danger to the community, he should not be released, if one can make that determination that he is a danger to the community.

Now, how do you make that assessment? How do you make that assessment, Senator? Purely on the record? Yes, the record is important. The record is very important, and there have been cases where I have disagreed with other members of the Board, where I have said this person is not ready for release, or this person does pose a significant danger, and so you do not release that person.

Now, let me tell you one other thing, Senator. We are constantly in conversation with administrative staff at the institution. There are cases where they have said to us, "Please advance this young man's hearing date," or "Please consider this young man for parole. We need the space."

And we have said to them, "Regardless of what your space needs are, in our opinion, this person should not be released," and he is not released.

Of course there is concern for the danger and safety of the community. I live in the community, Senator. I live in the community. I live at First and Bryant Streets, in the heart of the community where much of these things take place. I have a wife; I have friends for whom I have concern.

I have a member of our staff who within one block of the Board's offices was viciously attacked by two young men who attempted to rob him, and he was out of the office for 6 months. I have concerns about those, Senator. I am not insensitive to these things.

Of course we have concerns.

OVERCROWDING AND RELEASE OF PRISONERS

Senator SPECTER. Are release decisions made by the Parole Board out of any consideration to the overcrowded conditions of jails?

Ms. JUST. We do not release on that basis, Senator. You asked me about that when we were here before. We do not release on that basis.

NOTIFYING OTHER LAW ENFORCEMENT AGENCIES

Senator SPECTER. Chairman Just, you have indicated in a followup response from the last hearing that during a 45-day period no law enforcement authorities objected to the release of any person on parole, and that raises a question in my mind as to what notice, if any, is given to the law enforcement officials of parole hearings for persons convicted of crimes of violence.

Ms. JUST. The Board itself does not advance notice to law enforcement officials. The U.S. Attorney's Office has the same information concerning parole eligibility that the Board has.

Senator SPECTER. Do you give the U.S. Attorney notice of the hearings which you are contemplating?

Ms. JUST. No, we do not.

Senator SPECTER. Do you give the victims any notice of the parole hearings?

Ms. JUST. No, we do not.

Senator SPECTER. Do you think that it might be a good idea to give notice to victims or to law enforcement officials so that they would have an opportunity to come forward and give you their views as part of your input on your final decisionmaking?

Ms. JUST. That is certainly something that we could give consideration to.

It has been the practice of the U.S. Attorney's Office in the past to write to the Board when it had very strong feelings about the upcoming parolability of someone.

Senator SPECTER. How frequently does the U.S. Attorney's Office do that?

Ms. JUST. Very infrequently.

Senator SPECTER. How many times in the past year?

Ms. JUST. I think I have seen—and I will not say that this is within the past year—but in the time that I have been on the Board, perhaps three or four such letters.

Senator SPECTER. And how long have you been on the Board?

Ms. JUST. Since 1979.

Senator SPECTER. How would they know whom to write about, Chairman Just, if they do not know who is going to be coming up for a hearing?

Ms. JUST. I think what their practice has been, Senator, is at the time of sentencing, at the time that the person is committed, to write that letter and to recount the specifics of the offense and to state their position. I suppose it is very similar to that of the allocution at the time of sentencing.

Senator SPECTER. Chairman Just, I can understand the difficulty, and I understand what Reverend Ferrell is saying about the difficulty of making judgments on individual cases. But if you will permit me a suggestion, and this is obviously a judgment which the Board has to make, that you do adopt a practice of notifying the U.S. Attorney and notifying the victim of the date for a hearing so that if they have an objection or they have some facts to present to you, that they would have an opportunity to be heard, and then if they do not step forward, it would be another matter as to their later disagreeing with your conclusions.

But notice and an opportunity to be heard might be of some assistance to the Board in coming to your final conclusion.

APPROPRIATE RATE OF RELEASE

Chairman Just, your statistics indicate that in 1982, 61 percent of the adults are granted parole at their first eligibility date, and 73 percent are paroled at the next hearing, but almost 90 percent are paroled at their first or second eligibility hearings. Do you believe that that is an appropriate rate of release, considering the early points of those first and second eligibility hearings?

Ms. JUST. Let me start, Senator, by saying that the court sets the minimum time that a person must serve. The court sets the maximum time that a person may serve. The court, by setting this span of sentencing, is leaving to the Parole Board the decision to make as to whether the person's progress in the institution is such as to warrant a grant of release.

When we deny at the initial hearing, it is usually for very specific reasons, and if these deficiencies are met by the time of the second hearing, then there is a valid basis for making a grant at that time.

I am not able to say, based on any kind of empirical data, that a 60-percent rate is appropriate or a 70-percent rate is not appropriate. I just cannot answer.

Senator SPECTER. Chairman Just, do you have adequate personnel in the facilities to discharge your duties of the Parole Board?

Ms. JUST. We have a very fine parole staff, and we are working that staff to its maximum output.

SUFFICIENT PERSONNEL AND RESOURCES

Senator SPECTER. You feel you do have sufficient personnel and resources for your job?

Ms. JUST. Our resources are adequate to our present hearing load. If that load were to increase, then we would certainly need additional resources.

Senator SPECTER. But as things stand now, you would not be requesting of this subcommittee any additional funding?

Ms. JUST. If the subcommittee were to invite us to—there is additional staffing that we would like to have, but in terms of meeting our basic obligations, we are doing that. I am speaking now of the conduct of hearings.

But one of our deficiencies, and I think that this is a deficiency on the part of parole systems across the country, is that we have not been able to generate the kind of data, data analysis that would give you more ready answers to your questions. We have just recently, through some savings that came about with the loss of staff, set up an office of planning and data analysis, which we hope to have staffed very soon. We would like to have a statistician. We would like, in time, to have an additional hearing examiner. We have already increased our hearing examiner staff.

Senator SPECTER. Well, we are sympathetic to your problems and are interested in knowing could have an effect on your doing a better job. I do not need to tell you how tight money is, but part of the function of our inquiry is to see how we can be of assistance to you.

Ms. JUST. We can foresee that with the additional funds that have gone to the Department of Corrections that should the additional staff there generate a larger hearing load for us, then we very definitely will need additional staff resources.

REMARKS OF BOARD MEMBER GIBSON

Senator SPECTER. Mr. Gibson, we have not heard from you today. Would you care to make a comment?

Mr. GIBSON. Yes, I would.

Senator SPECTER. Please do.

Mr. GIBSON. And if you had not called on me, I would have reminded you of your last statement at the last hearing that you wanted to hear from me.

Concerning the initial question you raised and the information we gave in the 1982 annual report—we did a 5-year study—I think it is significant that we did so without the staff that the chairman was just talking about. So much so that when we got back to the office, we looked to see specifically what we were talking about and what that 40 percent meant, and we could not determine whether or not we were mixing apples and oranges in the count, or was it just a count for count's sake.

We then went into an analysis of 1982 and what had happened there, particularly in terms of rearrest, and what we found was that of some 3,700, more than 3,700 parolees on the street in 1982, there were 1,233 rearrests during that period of time, in that year, on felony cases. However, 171 were convicted of those rearrested on felony cases. Some 5 percent of the parolees under supervision at that time.

Senator SPECTER. What happened to the balance of them?

Mr. GIBSON. What happened to the balance of them? Some of them stayed in jail a long time on detainer. Some of them were put back out on the street because they could post bond.

Senator SPECTER. You say 1,200 were arrested and some 100 were convicted?

Mr. GIBSON. 171 were convicted; some 5 percent of the total under supervision.

Senator SPECTER. Are you saying that the balance were acquitted?

Mr. GIBSON. The balance were either acquitted, no-papered, or somehow within that system were not convicted for the arrest that was made.

Senator SPECTER. Give me those statistics again, if you could please.

Mr. GIBSON. All right. There were 1,233 rearrests of parolees in 1982 on felony cases. There were 171 convictions of parolees on felony cases.

Senator SPECTER. That would be a very low conviction rate if, in fact, the balance were acquitted or no-papered. Some of those cases——

Mr. GIBSON. Some of them may have gone over to another calendar year.

Senator SPECTER. They may still be pending.

Mr. GIBSON. That is right.

Senator SPECTER. Mr. Harris, may I ask you to check that out for the committee as to what has happened there, because if Mr. Gibson is suggesting that only 171 out of 1,233 were convicted, then it would suggest that the judgments of the Parole Board were not too bad, but I would like to know what happened in those cases.

Mr. Harris. I would be happy to.

Senator SPECTER. Thank you.

STATEMENT OF JUDGE HARRIS

Mr. GIBSON. I would like to also make another observation, and that was the initial statement made by the U.S. Attorney that the corrections system within the District of Columbia is the second most dangerous in the country, but we could not find what statistics they were quoting from. We could not determine whether or not this was a personal statement made by a Justice Department official, and it would be interesting to know whether the statement was based on a stereotype that all blacks are dangerous. It would be interesting just to know that.

Senator SPECTER. We will give Mr. Harris a chance to comment on that.

Mr. GIBSON. I think the person who made the statement should comment on it, sir, and be prepared to show some statistics. That is a dangerous statement to make about this community.

Second——

Senator SPECTER. Well, I asked Mr. Harris for the evidentiary base of it.

Mr. GIBSON. Thank you. All right.

Senator SPECTER. He did not have it.

Mr. GIBSON. It reminded me a little bit of about 10 to 12 years ago when the national news was quoting some very high U.S. officials that Washington, D.C., was the crime capital of the world, when statistically we were really No. 5 or 6 or somewhere down the line as far as the crimes committed in the various jurisdictions of this size in the country.

Senator SPECTER. Mr. Gibson, I do not believe that there is any imputation here on a racial basis, that anybody is suggesting that all blacks are dangerous or that there is any racial overtone.

Mr. GIBSON. It raises it in my mind, sir, and some of the people that I talk with in my community, and you know, you have to wonder about that particularly when statements can be made and no basis for them are given. It impugns us.

Senator SPECTER. Well, there is no racial overtone raised in my mind about it.

Mr. GIBSON. I did not think it would be.

Senator SPECTER. To say that there is a degree of dangerousness in one prison or another is not to say what the racial makeup of that prison is compared to any other prison.

Mr. GIBSON. That is right, but the only other one that they compared it to was the boat lift population. Significant.

Senator SPECTER. The boatlift population is different because there is evidence or a suggestion that those individuals were hardened criminals as a group, not that they had any necessary racial background, but that the selection of them had come from a very hardened criminal class.

Mr. GIBSON. I understand.

Senator SPECTER. They were excluded from their native habitat because they were such hardened criminals and sent to the United States.

Mr. GIBSON. I understand.

Senator SPECTER. But do you see any racial connection there?

Mr. GIBSON. There may be, sir. I really do not know.

Senator SPECTER. Well, I think speculation along that line is very questionable on anybody's part. If anybody has anything to say that has a racial basis, they ought to have their evidence in hand before they start to say it on any count.

Mr. GIBSON. Well, I raise the point because that statement has been made several times unchallenged, and I wanted to raise the question on the record as to why.

Senator SPECTER. But have you ever heard the statement made in the context that there is any blame imputed to any special racial group?

Mr. GIBSON. No, but there is a stereotype that I have lived with for most of my life, coming out of Georgia as I do, that there is something sinister about blacks.

Senator SPECTER. I do not think that was intended, but I do think Mr. Harris ought to have a chance to comment on it.

Mr. GIBSON. Thank you.

Senator SPECTER. Anything further, Mr. Gibson?

STATISTICS OF PERSONS REARRESTED

Mr. GIBSON. Based on what we were able to find in terms of the 1982 statistic, I raise a very serious question about the 47 percent of the people on parole being rearrested, quote, in the first 10 months of 1983.

Senator SPECTER. What is the basis for your questioning that statistic?

Mr. GIBSON. Well, it would seem that the inference there is that because they were arrested, they were guilty, and arrest is one thing, but conviction is another. I go back to Justice Berger's ruling, the Supreme Court ruling—I do not have that particular citation before me—that a parolee, once paroled, has the same right to due process, as you know, as any other person within freedom, and I would hope that we would not think that just because people were rearrested and they were a parolee that that presupposes guilt.

Senator SPECTER. Mr. Gibson, that is not quite right. When someone is rearrested, a parolee, for a revocation of a parole, there does not have to be a determination of proof beyond a reasonable doubt as there does for the conviction of the second offense. You are not correct in what you are saying.

If John Defendant has been released on parole on a burglary charge and then he is rearrested on a second burglary charge, to convict him of a second charge there has to be proof beyond a reasonable doubt that he is guilty of the second charge. To revoke his parole from his first conviction, you do not have to do that.

Mr. GIBSON. No, I did not mean that.

Senator SPECTER. But that is what you said. A parolee's right are not the same in terms of revocation of parole contrasted with conviction for the subsequent arrest.

Mr. GIBSON. OK. They still have to have due process, but to detain them—and let's say we did revoke—and if the 1982 figure is born out that only 5 percent were really guilty, according to a court of law, the question is: At what time do we determine that just an arrest, constitutes a violation of parole.

Senator SPECTER. An arrest is not sufficient. You are quite right. There has to be a hearing by the Parole Board.

Mr. GIBSON. Right.

Senator SPECTER. And the Parole Board has to make a determination beyond the fact that a man was arrested, but the Parole Board does not have to have evidence to prove it beyond a reasonable doubt.

Mr. Gibson, you are raising some important questions, and I can see that you doubt what the U.S. Attorney has said based on the 171 who were convicted, and I think these are important statistics, and I intend to pursue them, as to what happened with the 1,233 who were rearrested, and you raise an important question about what happened with the 47 percent of the 404 defendants. That has to be determined.

There is a sharp difference of opinion between the U.S. Attorney's Office and the Parole Board as to the adequacy of the releases. I think that is plain from what is happening and the testimony presented here, and I think we have to take a closer look at just what has happened to see what is being undertaken.

Certainly the Board is doing its best, and I can sympathize with Reverend Ferrell who has questions about, is the job worth doing. I think we all have questions about whatever we do in that respect.

Ms. JUST. Senator, with reference to the figures that Mr. Gibson mentioned, I think that that 1,200 figure pertains to arrests, not persons, but the number of arrests, whereas the 171 pertains to persons, and the 3,700 under supervision pertains to persons.

Senator SPECTER. Well, I do not know whether it does or not, Chairman Just. I think the 1,233 may relate to persons. They are rearrested. It is questionable that they are going to be rearrested twice, if they are on parole, rearrested, and then released again. My instinct would be that it relates to persons.

Mr. Harris, would you care to make a comment about the statements which Mr. Gibson has made, if you care to?

Mr. HARRIS. No, thank you. I said all that I think needs to be said on this subject.

Senator SPECTER. All right. Fine. Does anybody else have anything they would like to add at this point?

Reverend Ferrell, would you like to conclude?

Mr. FERRELL. Just, Senator, I realize that I got very emotional. I apologize for that.

Senator SPECTER. I do not think you got emotional.

Mr. FERRELL. I do hope though that what came through is that this Board is very conscious of its responsibilities, both to the inmate population and, just as important, to the community in which we all live.

We are called upon to make weighty decisions, to make those decisions not out of prejudice or preconceived conditions, but rather to consider and weigh the factors that we have before us and to the best of our ability make judgments based on that, and I pledge to you, Senator, that for the balance of the time that I am a member of this Board, which will not be too many more months, that is what I plan to continue to do.

Thank you very much.

SUBCOMMITTEE RECESS

Senator SPECTER. Thank you very much, ladies and gentlemen. We very much appreciate your all coming. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:27 a.m. Tuesday, November 1, the subcommittee was recessed to reconvene at 10 a.m. Tuesday, November 8.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

TUESDAY, NOVEMBER 8, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:08 a.m. in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Members present: Senator Specter.

Staff present: Lynda Nerseian, Chief Counsel; Terry Campo, Counsel; Veronica Gonzales, Virginia Chamberlin, and Jeff Goodman.

DISTRICT OF COLUMBIA

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

STATEMENT OF HON. H. CARL MOULTRIE, CHIEF JUDGE, SUPERIOR
COURT OF THE DISTRICT OF COLUMBIA

ACCOMPANIED BY LARRY POLANSKY, EXECUTIVE OFFICER OF THE DISTRICT OF COLUMBIA COURTS

SUBCOMMITTEE PROCEDURE

Senator SPECTER. We will convene the hearing of the District of Columbia Subcommittee of the Appropriations Committee, and today we will focus on the issue of the need for additional judges for the District of Columbia Superior Court.

The superior court, which was created by the District of Columbia Court Reorganization and Criminal Procedure Act of 1970, had 44 judges fixed by statute since that time. Over a number of years, an increased volume of cases has led to recommendations to add additional judges. For example, since 1978, criminal case filings have increased from 26,420 to 33,589. Pending felony indictments have increased 35 percent from 1981 to 1982, and jumped an additional 9 percent in the first three quarters in 1983.

By the end of 1982, the court had over 38,000 pending cases. Two separate studies have been made of the superior court's backlog problems. Last year's Horsky committee report recommended the judges handling felonies should have caseloads of no more than 100, and those handling misdemeanors no more than 300.

Current caseload levels are double that in each category. Extrapolate-

tions from the Horsky committee report would suggest that at least 12 new judges are needed. Dean Ernest Friesen's judicial resources study last year suggested that 11 judges are needed now. Thus, it would appear that seven is a conservative number.

Of particular concern are the felonies awaiting trial. As Chief Judge H. Carl Moultrie of the superior court noted in an October 24 letter to D.C. Mayor Marion Barry, there are over 2,000 serious felonies awaiting trial, 1,284 of which are more than 180 days old. Both the persons charged with these serious crimes and the public at large deserve prompt resolution of these matters so that the guilty may be appropriately sentenced and the innocent released.

This year, the Senate's 1984 budget for the District contained authorization and funding for the seven new judges. Although the authorization was dropped in conference at the request of the House, the \$2.8 million needed is still available as soon as authorizing legislation is passed.

We are pleased to welcome several distinguished witnesses this morning. Chief Judge H. Carl Moultrie has served as chief judge of the superior court since June 1978. He recently wrote Mayor Barry to urge his support for the additional judges. The Mayor's Office is represented today by Betsy Reveal, Director of Budget. Francis Carter, the Director of the Public Defender Service, is also present. On such short notice, we were unable to obtain the U.S. Attorney for the District of Columbia, but we hope they will send their views and statistics in writing at a later time.

We will turn at this time to the distinguished chief judge of the superior court, the Honorable H. Carl Moultrie, accompanied by the very able Larry Polansky, Executive Officer of the District of Columbia Courts, whom I have known for many years personally. Mr. Polansky did some very fine work in the Philadelphia Court of Common Pleas.

Welcome, Judge Moultrie, and Mr. Polansky.

OPENING REMARKS OF JUDGE MOULTRIE

Judge MOULTRIE. Thank you, Senator.

I am pleased to be here, not necessarily to defend, but to talk about the need for these seven judges. I have submitted to you a statement, and with your permission, Senator, we will also offer some charts.

As a court of general jurisdiction for this city, the superior court is confronted with a complex caseload. As of September 30, 1983, we had 2,061 serious felonies awaiting trial.

Senator SPECTER. As of September 30? Would you repeat that date, please?

Judge MOULTRIE. Pardon?

Senator SPECTER. As of what date was that? Would you pull the microphone just a little closer to you? Thank you.

BACKLOG OF FELONY CASES

Judge MOULTRIE. As of September 30, 1983, we had 2,061 serious felonies awaiting trial, which is a substantially larger number than those pending as of September 1982, despite the fact that we have tried 511 felony cases through September of this year.

Senator SPECTER. Judge Moultrie, do you have a figure for September 30, 1982?

Judge MOULTRIE. For September 30, 1982?

Senator SPECTER. Yes.

Judge MOULTRIE. 419 jury trials.

Mr. POLANSKY [pointing to chart]. Senator Specter, October 1 is at this point on the chart. There was well under a 2,000-case backlog at that time. I would note, also, that the addition of hearing commissioners in October 1982 took us through a small drop in the pending caseload. However, we have more than eaten up the advantage by now and the felony backlog has also climbed. The projected figure shown on the chart for October is now a real figure.

Judge MOULTRIE. The figure for October 31, 1983, is 2,104 felonies awaiting trial; 767 in the grand jury section; and 231 awaiting preliminary hearing. That makes a total of 3,102 serious felonies.

Senator SPECTER. Let me see if I can follow the jump; 3,102, you say?

Judge MOULTRIE. Yes, 2,104 of those felonies are serious felonies awaiting trial and, of course, we also have 677 in the grand jury.

Senator SPECTER. 677?

Mr. POLANSKY. 767.

Judge MOULTRIE. 767.

Senator SPECTER. In the grand jury?

Judge MOULTRIE. Yes, and 231 preliminary hearings.

Mr. POLANSKY. Now, we have shown you the pending chart. We also have some time problems with those cases, as you are well aware. The chief judge indicated to me that a number of these cases have been pending for quite a long period of time.

We would like to show you some of the information we have on the amount of time these cases have been pending. This dark area represents the goal that the chief judge has for the times within which cases should be disposed of, and you can see that he believes felonies should be disposed of within 100 days of indictment, actually, slightly less than 100 days from indictment; misdemeanors in 60 days; and juvenile cases about 30 to 45 days. Those are ideals that he would like to be able to achieve.

The Whittier group, when they did their study, came up with numbers that were slightly higher than the chief judge's ideal. They were about 90 days from indictment for felonies. They were at the same 60-day level for misdemeanors, and they were at about 45 to 50 days for juvenile cases.

Our 1980 studies showed significantly higher actual numbers. Felonies were up to about 180 days. Misdemeanors were off the chart, something like 240 days. and juveniles were at about 60 days. And we have

brought our information up to date. Felonies have now gone completely off the chart: this column indicates 270 days from indictment to judgment. To this you would have add——

Senator SPECTER. 217 days to verdict, you say?

AVERAGE TIME FROM ARREST TO INDICTMENT

Mr. POLANSKY. To verdict. The average from arrest to indictment is approximately 67 days, based on our numbers. That would bring this to 284, and then——

Senator SPECTER. That is indictments to verdicts?

Mr. POLANSKY. This is indictment to verdict.

Senator SPECTER. So arrest to verdict is what?

Mr. POLANSKY. At about 67 days on average, from arrest to indictment. That brings us to 284 days.

Senator SPECTER. 274 days from arrest to verdict?

Mr. POLANSKY. I think it is 284.

Senator SPECTER. 284.

Mr. POLANSKY. And then on average, at least 42 days from the presentence investigation preceding sentence. So that the typical felony case that goes to trial and sentencing is over 320 days.

Senator SPECTER. 326 days. That is the average?

Mr. POLANSKY. Yes, sir.

NUMBER OF FELONY CASES ON BAIL AND IN CUSTODY

Senator SPECTER. Do you know how many of those cases are on bail and how many are in custody?

Mr. POLANSKY. I believe the chief judge has that information.

Judge MOULTRIE. Yes, sir. Of the 3,102 felony cases as of October 31, 1983, 1,117 are in jail; 1,985 are on bond of some fashion.

Senator SPECTER. Do we know how many of those on bond have been rearrested for other charges?

Judge MOULTRIE. I don't have that figure, but I could get it, sir.

Senator SPECTER. Could you give me an estimate, Judge Moultrie?

Judge MOULTRIE. I wouldn't want to take a guess. I will find the figure out for you. My guess, though, is, that if they have been rearrested, they are likely to be in jail, because they would have a record. I don't, however, want to make that definite statement——

Senator SPECTER. I don't think so. I don't think so, when they are rearrested on bail for a charge. If they are rearrested on probation, yes, but not if they are rearrested——

Judge MOULTRIE. Senator, if a defendant is brought in, he is out on a charge, a felony charge, and he is brought in and on another one, the judge would certainly look at that very carefully to determine whether or not he should be free. That is why, until I get some definite figures, I would not want to guess that figure.

Mr. POLANSKY. Senator, if I could continue, you will note that there was a tremendous improvement made in misdemeanor cases. The 240 days are 1980, down to 119, but that is only the good news. We have

been down as low as 90 days; however, in the last 18 months, we have climbed back up to that 119-day level.

Now, that does include sentencing. That figure is from arrest to disposition.

IMPROVEMENT IN BACKLOG OF MISDEMEANOR CASES

Senator SPECTER. Have the misdemeanor cases had a backlog improvement as a result of extra judicial personnel being applied to that issue?

Mr. POLANSKY. Oh, certainly. It is the result of a combination of three additional hearing commissioners providing additional available judges, and the chief judge adding one or two individual judge calendars, to the misdemeanor program over the past 2 years, and control. Control of the number of days permitted between stages of the case was proposed approximately 3 years ago and implemented in 1981.

Senator SPECTER. Has the misdemeanor backlog been reduced at the expense of the increase in felony backlog?

Mr. POLANSKY. I must say that the misdemeanor backlog has not been reduced. What has been reduced has been the time from arrest to disposition. Our backlog continues to rise, as you will see in the next part of the statement.

Senator SPECTER. Mr. Polansky, how can that be? That would be surprising statistically if the backlog is not reduced but the time for disposition between arrest and sentencing is reduced.

Mr. POLANSKY. One of the many complaints of those who criticize the court systems is that we don't work in the most efficient fashion. This court, as many other courts, has had problems with overscheduling and overcontinuing cases. A number of wasted effort factors were cleaned up over the last few years, which resulted in a tremendous reduction in the time from arrest to disposition for misdemeanor cases.

However, all it did was to speed up the disposition of specific cases. It did not tremendously increase our ability to address the additional caseload, and there has been significant additional caseload in the misdemeanor and in the felony areas.

Judge MOULTRIE. In our present misdemeanor cases, Senator, we now have 3,692 cases awaiting trial as of September 30, 1983, and as of October 31, figure, we have 3,803 cases.

You mentioned the Horsky committee's report a minute ago, Senator, in which the Horsky committee suggested that misdemeanor calendars and felony calendars as handled by judges were overloaded. For your information, sir, we have nine felony calendars, and one of those calendars has 230 cases. Another has 261, another has 189, one has 217, one has 247, one has 232, one has 196, another has 222, and another 208. All are well above the suggested calendar limits suggested by the Horsky committee. In addition to that, for the misdemeanor calendars—listen to these figures: One has 620 cases, 556 cases, 540, 509, 562, 504, 441. Those are all well above the suggested calendar load for a judge.

INDIVIDUAL JUDGE CALENDARS

Senator SPECTER. Do you have the individual judge calendar, Judge Moultrie?

Judge MOULTRIE. Yes, I do. I just gave you the individual ones, other than by name.

Senator SPECTER. That is what I thought.

Mr. POLANSKY. Senator, that is relatively recent. They did have a master calendar system up to several years ago, and the individual calendar is part of the reason for the turnaround in the time from arrest to trial for misdemeanor cases.

DISTRIBUTION OF 44 JUDGES

Senator SPECTER. How many judges do you have? Does every one of the 44 superior court judges have a misdemeanor and a felony list?

Judge MOULTRIE. Oh, no, sir. We have 22 judges in the criminal section. We have nine of those judges in felony II's; we have three in felony I's; and we have seven in misdemeanors, along with one in traffic and two swing judges.

Senator SPECTER. And the other 22 judges are not handling criminal cases?

Judge MOULTRIE. They are not handling criminal cases on a felony level. Some are in family, some in civil. Those in family court handle criminal juvenile cases, but are not in felonies.

ASSIGNMENT OF JUDGES

Senator SPECTER. Are the 22 judges in criminal court permanent assignments?

Judge MOULTRIE. There are no permanent assignments, Senator. Our judges rotate. Felony assignments are made on a yearly basis; misdemeanors are on a 6-month basis.

Senator SPECTER. So when you replace a judge, another judge simply takes over?

Judge MOULTRIE. Takes over his calendar.

Senator SPECTER. His calendar?

Judge MOULTRIE. Yes, the calendar, and all the cases.

Mr. POLANSKY. Senator, if I could show you this chart, it shows a decline and then a rise in the misdemeanor backlog over the past 13 months. The projection for October has, unfortunately, been borne out, and we are at 3,800 cases, which is the highest level of misdemeanor backlog over this 2-year period. I believe that in the 5 years I have been here it has not been over 4,000, but we are about to get to that level.

Judge MOULTRIE. Senator, let me give you a figure that you asked for with reference to misdemeanors, those persons in jail. Misdemeanors: Of the 3,803 cases pending, 494 are actually in jail and 3,309 are on bond in some form.

Senator SPECTER. Go ahead.

CALENDAR DAYS IN HORSKY REPORT

Mr. POLANSKY. The chief judge mentioned the Horsky report and recommendations that no felony calendar should have more than 100 cases and no misdemeanor calendar should have more than 300 cases. We have taken the liberty of analyzing those numbers and computing our needs. If we were to now project the Horsky report needs, it would require four misdemeanor judges to make up the difference necessary to bring those calendars down to 300.

We would need eight more felony judges to bring felonies down to 100 cases for each individual calendar. All through the Horsky report, there are indications of need for civil, family, and probate judges. This would call for another six judges. The total judge need now is not the 12 needed in our first extrapolation based on Horsky's figures, but is now 18, a dozen of which are in the criminal area. This is based on their rule-of-thumb calculation.

Now, we would not accept that as the only calculation of how many judges are needed, but we would like to point out that if one reads the Horsky reports, one would believe we need 18.

NUMBER OF MISDEMEANOR CASES IN JAIL AND NUMBER ON BOND

Senator SPECTER. Judge Moultrie, would you give me those figures again? Out of 3,692 misdemeanor cases, how many of those are in jail and how many on bond?

Judge MOULTRIE. Of the 3,803 as of October 31, misdemeanor cases——

Senator SPECTER. All right.

Judge MOULTRIE [continuing]. 494 are incarcerated; 3,309 are——

Senator SPECTER. 3,309?

Judge MOULTRIE. Yes, sir, that is correct.

Senator SPECTER. Why are there so many misdemeanor cases incarcerated? They are serious enough that substantial bail is required?

Judge MOULTRIE. Yes, based on criminal records, and based on failure to return to court. There are many reasons why they are incarcerated. Keep in mind, though, that 87 percent of these are not incarcerated.

NUMBER OF CASES AWAITING DISPOSITION

Senator SPECTER. When you say the average, 326 days in felony cases from arrest to sentencing, what is the longest case, from arrest, you have that hasn't been disposed of by sentence?

Judge MOULTRIE. I don't have that figure, but there may be some cases that are awaiting insanity dispositions. There are many reasons. I couldn't give you the figure, now, but, I could find out how many we have that are waiting for specific purposes.

Senator SPECTER. If your average is 326 days, you must have many which are well over a year, and probably some in excess of 18 months, without some reason like an insanity issue.

Judge MOULTRIE. There are many reasons for the cases to be waiting. It could be codefendant trials or it could be involved in a fugitive de-

fendant situation. I could find out for the record how many cases are waiting, but there are many reason they could be waiting.

Mr. POLANSKY. Senator, if you would like us to prepare a report to give you some idea of the times for those cases that fall above the 326 level, we would be pleased to do that.

Senator SPECTER. I would be interested to know that, Mr. Polansky, because the 326-day figure is just an enormously serious thing all by itself. To have 1,985 defendants charged with serious felony cases on bond is an intolerable situation. I know that is something that you agree with, Judge Moultrie. I am sure you find it intolerable to have this kind of a situation, or do you?

Judge MOULTRIE. I do, sir. My projection is that if the superior court cannot dispense justice quickly, it is justice denied. There is no question in my mind about it.

Senator SPECTER. Well, you have, out of the 3,102 felony cases, 1,100 in jail, almost 2,000 on bond, and for the period of time that the defendants are being detained, there is a serious issue of their constitutional right to a speedy trial, and there is enormous danger to the community from these people on bond, some of whom, at least, are committing other offenses, are charged with other offenses. I would be interested to know, Judge Moultrie, how many of the 1,985 have been rearrested for a subsequent charge while on bond.

REARREST OF PERSONS ON PRETRIAL RELEASE

Judge MOULTRIE. We will give you those figures.

Senator SPECTER. Because I have had a lot of experience in this field, and I have an instinct that there are many.

Judge MOULTRIE. All right, sir.

Senator SPECTER. Those statistics paint a very serious picture.

[The information follows:]

REARRESTS OF PERSONS ON PRE-TRIAL RELEASE FOR CASES FILED
IN OCTOBER 1983

	CASES FILED OCTOBER	CASES INVOLVING PERSONS ON PRE-TRIAL RELEASE	% OF CASES INVOLVING PERSONS ON PRE-TRIAL RELEASE
FELONY CASES	607	43	7%
MISDEMEANOR CASES	1521	102	7%
TOTAL	2128	145	7%

ANALYSIS OF TIME PENDING
FROM INDICTMENT
FOR OPEN FELONY CASES
AT 10/31/83

0 - 149 DAYS	34%	34%
150 - 199 DAYS	13%	47%
200 - 249 DAYS	13%	60%
250 - 299 DAYS	11%	71%
300 - 349 DAYS	7%	78%
350 - 399 DAYS	5%	83%
400 - 449 DAYS	4%	87%
450 - 499 DAYS	3%	90%
500 - 549 DAYS	2%	92%
550 - 599 DAYS	2%	94%
600 DAYS AND OVER	6%	100%

ANALYSIS OF TIME
FROM INDICTMENT TO VERDICT
FOR CASES WHICH WENT TO TRIAL
1/1/83 - 9/30/83

		<u>WILSONVILLE</u>
0 - 149 DAYS	19%	19%
150 - 199 DAYS	13%	34%
200 - 249 DAYS	12%	44%
250 - 299 DAYS	9%	53%
300 - 349 DAYS	10%	63%
350 - 399 DAYS	10%	73%
400 - 449 DAYS	6%	79%
450 - 499 DAYS	7%	86%
500 - 549 DAYS	4%	90%
550 - 599 DAYS	3%	93%
600 DAYS AND OVER	7%	100%

STATUS OF SEVEN NEW JUDGES

Senator SPECTER. Where do we stand, Judge Moultrie, on efforts to get the final step through on the House of Representatives authorization? We have the appropriation, as you know, for the seven additional judges. We have worked that through on the Senate side from initiatives taken by this subcommittee, as I know you realize.

Judge MOULTRIE. Yes, I understand that.

Senator SPECTER. And on conference it was felt necessary by the House members that the appropriation be made contingent on authorization, so we are awaiting that final step, and I know you have been an activist, as you should be as the chief judge, in trying to get the last step done. What is the status of it, as you understand it?

Judge MOULTRIE. Well, I understand there has been a bill introduced in the House to authorize the seven judges. However, the committee itself to date is not discussing the matter. As you know, Congressman Fauntroy opposed the idea, according to the press. I don't now know whether or not there will be some more discussion with Congressman Fauntroy about the matter. I wrote him a letter yesterday asking him to reexamine his position in connection with the authorization.

Senator SPECTER. I am familiar with what Congressman Fauntroy said, and I am familiar with your letter, and we do have a copy of it, and we will try to be of assistance here on that subject.

Well, the statistics are overwhelming. They tell the story. No question about the need for the seven judges. No question about the need for more. What is not really understood is the tremendous impact on public safety caused by having 1,985 defendants on bond in serious felony cases and 3,309 in misdemeanor cases, and the serious impact on the constitutional rights of those who are incarcerated, of having some 1,611 in jail awaiting trial for very protracted periods of time. And that causes the difficulty at the D.C. Jail, as we all know.

Judge MOULTRIE. I quite agree, sir.

Senator SPECTER. You have quite a bottleneck.

Judge MOULTRIE. Sir?

Senator SPECTER. You have quite a bottleneck there, and I don't say that in any critical sense toward the court. It is a problem you need help on.

Mr. POLANSKY. It is one that we live with every day.

We wanted to point out, however, that we have done our homework. The critics of the court system say that before you ask for additional judicial positions, you must do your homework; that is, evaluate your system. We have done several evaluations and have had independent evaluations of our system by national experts who have made their pronouncements regarding the need for additional resources.

We have changed assignment and calendaring techniques. The court is no longer on a simple master calendar. We have gone into individual case calendars in the criminal program and in the civil program, and have had these calendars for several years now in major civil cases. That has created improvement, but has not solved the problem.

We have reallocated our resources. We have looked at the number of people who work in each of the divisions of the court and moved them around. The chief judge has transferred judges from division to division trying to meet the backlog. We have used senior judges to the best of our ability and their physical ability, and, with the help of your committee, we have been provided with funds for three hearing commissioners, which has enabled us to use three additional judges in the criminal programs.

We have done our homework. We have used alternatives, but have not found the solution.

I would point out the top line of this next chart reflects our combined pending caseload. If we were IBM that curve would represent a nice excellent increased profits on sales. Unfortunately, what it shows is an increase in the pending backlog in the combined criminal, civil, and family caseload. We actually have increased in each of the areas over the past 6½ to 7 years.

USE OF MORE JUDGES ON CRIMINAL CASES

Senator SPECTER. Chief Judge Moultrie, have you considered taking more judges from the noncriminal side to try to bring down this felony list?

Judge MOULTRIE. I can't; I cannot. The other divisions are suffering also, Senator. We cannot. That is why we need these judges.

Mr. POLANSKY. In partial response to that question, Senator, the average time now for a domestic relations case—divorce, property settlement, child custody—is 498 days. The model, Chief Judge Moultrie's model, calls for the determination of those cases in 30 days. We are somewhat off the track, and I think part of the reason for that, is—

Senator SPECTER. And civil cases are what?

Mr. POLANSKY. 785 days for what we call civil I cases. I think Philadelphia would call them major civil cases. 785 days from issue to disposition.

The more normal and average civil case which includes cases from \$751 and up—

Senator SPECTER. It is always a difficult matter as to how you are going to allocate resources, but some jurisdictions have allowed the civil backlog to go substantially longer than that in deference to the criminal backlog.

Judge MOULTRIE. We have done this also, we have 22 of the 44 judges in criminal work and we have civil probate, tax, and family cases as well. We have done the same thing.

Mr. POLANSKY. And this court is like a combination of the municipal court and the court of common pleas, so that all the municipal activities—landlord and tenant housing cases, small claims—all of that is in the other 22 judges.

ASSIGNMENT OF JUDGES

Senator SPECTER. Judge Moultrie, have you considered having the individual judge calendar and have the judges assigned to all divisions at the same time? The Federal system does that. For example, when a case comes into the Federal Court for the Eastern District of Pennsylvania, whatever kind of a case it is, it goes to an individual judge. It seems to me that the incentives for an individual judge calendar are lost when you have a judge assigned to criminal for 6 months or a year, and then he leaves that post and gives those cases over to another judge.

Judge MOULTRIE. Well, Senator, I think that would work if you were not dealing with such large numbers. They can do it in the district court because they don't have large numbers. We are talking about 2,000 felonies, and to have felonies, family and civil, I don't think it would work. If our number of cases were less, we perhaps could do that, sir.

Senator SPECTER. I don't know about that. It seems to me that the principal advantage for the individual judge calendar is having that judge know that once it comes to him, he has got it, and he has to conclude it, so that if there is a substitution of that list with another judge, that the incentives are gone, the principal incentive for case management and case disposition on the individual judge.

Judge MOULTRIE. Well, sir, there is also a morale effect. For example, a judge with 500 cases, and with more misdemeanor cases coming in every day, even when he disposes of large numbers of cases, he can make no headway on the backlog. The judge who started off on October 1, 1983, with 617 cases, received 175 new filings and there were 28 cases reinstated. He was transferred in 5 more cases, which made a total of 825 cases he had to dispose of for that month. There were 159 dispositions and 39 were placed on inactive status; there were 7 cases transferred out, for a total reduction of 205 cases, which still left him with 620 cases, or 3 more than he started with. He had 5 jury trials, 89 guilty pleas, 10 cases were dismissed, and 55 were nolle.

The point is, when these calendars are so heavy and you still receive more cases and work hard, yet, it appears you are not doing anything, it is really disheartening.

Senator SPECTER. Well, Judge Moultrie, I understand that, but that situation is going to be present no matter how you run your calendar when you have this influx of cases. I just make the suggestion to you for whatever you think it is worth.

Anything more, Mr. Polansky?

Mr. POLANSKY. One comment on what you said, Senator Specter. I agree in many ways with what you said, but on the other hand, the court's approach would work much more reasonably—and I think you might buy the 1-year assignment—if the court were disposing of cases in 120 days. Then most of the cases could get individual attention and would stay with that judge to completion. You would only lose the ones that came at the end of the judge's assignment.

Senator SPECTER. My job is not to administer the courts. I defer to Chief Judge Moultrie on that, but I would not agree with that. I realize that there are complications in having the judges operate at the same time in civil, criminal, and family lines of work, because it is a difficult administrative and management problem, and that there are certain efficiencies if you have one or two judges in criminal and then take the other 22 and put them in other lines.

But one of the grave problems that the judicial system has is in court management, and of all the problems, none has been as successful to my way of thinking as the individual judge calendar. Now, that requires that the judge be an administrator, and it is very hard to find good administrators anywhere, especially when you deal with judicial talents, which are not really directed in that line.

But my preference would be to see that once a case is assigned to Judge X, that he has it, and no way that case is going to go away until he concludes it, and if he has civil cases and criminal cases and family cases, then he has to make allocations in his calendar for disposition, and in the Federal system, the U.S. district court, their requirements on speedy trial, and the Federal district court judges give priority to the criminal cases, and I would not like to see civil cases or family cases slighted, but I would wonder if there ought not to be some greater priority to criminal cases here.

I realize that the chief judge is robbing Peter to pay Paul, and I know that, and it is not something you want to do, but I think that this community doesn't really know what is happening on recidivism out there with the kinds of trial delay that you have in the District. That is a hidden factor. The only people who know about it are the people who are victims, and even they don't know about what the records are.

MEDIA FOCUS ON SERIOUS ARREST CASES

When I was district attorney in Philadelphia, there was quite a media focus on the arrest on serious cases as to what the prior records were. I don't see that in the District of Columbia media.

Do I miss something, Mr. Polansky? You remember the days when somebody was rearrested on a felony charge and his record was printed, and he had five pending burglaries, and just as surely as I am sitting here, you have some of those cases in your court system. You have got a lot of them. You have to have a lot of them.

Judge MOULTRIE. Well, Senator, we have that now. Your aide was the man who brought that program to our court, sir, and he headed that program.

Senator SPECTER. Well, I am going to give him back to you. It seems to me you need him. [Laughter.]

Judge MOULTRIE. But I am saying, we have that now, sir.

Senator SPECTER. I am sure you do.

Mr. POLANSKY. I think the only difference is between the publicity in Philadelphia and here. The career criminal program is pursued here with vigor. As a matter of fact, in recent months, we have had a great deal of activity in that area.

OTHER JURISDICTIONS WITH INDIVIDUAL COURT CALENDARS

Judge MOULTRIE. Senator, do you know of any State trial court that has adopted your idea to calendar as in the Federal courts? I mean any trial court anywhere in the United States?

Senator SPECTER. No.

Judge MOULTRIE. I don't know of any, sir. You see—

Senator SPECTER. That is why I would like to see you the leader, Chief Judge Moultrie. I am trying to give you some help and some ideas. Maybe you will take some help—

Judge MOULTRIE. Senator, I promise you something. Give me some judges, and I will do it.

Senator SPECTER. It's a deal.

Judge MOULTRIE. Good.

Senator SPECTER. I will get you the seven judges, and you will put in an individual calendar across the board.

Judge MOULTRIE. Well, now [laughter]—

Let me put it this way. After I have reduced the calendar, yes.

Senator SPECTER. Oh, no. That's like build up and build down, Chief Judge Moultrie

ASSISTANCE IN GETTING SEVEN JUDGES

Judge MOULTRIE. Let's be frank about it. With the caseload, I couldn't do it. If you reduce my cases, I will do it.

Senator SPECTER. Well, I don't think that is going to happen. The situation that I would like to see, I would like to get you the seven judges, and when I leave here, and I am going to leave here soon so I can make these calls, I am going to call up the House members and tell them what I have seen today. I have withheld that.

But I would like to see, when you get 51 judges on your list—7 is a big number off 44. It is not as much as you need, but you haven't gotten there yet, but when you do get there, it is a significant day. I would like you to then project an individual judge calendar across the board, where you divide up these cases among all 51 of the judges, criminal, civil, family—

Judge MOULTRIE. Senator—

Senator SPECTER. You are going to have a tougher job as chief judge, but you can handle it. You are going to have a tougher job in administering those 51 judges who are all going to have to be separate administrators.

Judge MOULTRIE. Senator, when we get the judges, we will talk to you about it.

Senator SPECTER. OK.

Mr. POLANSKY. I think there are some ways to begin to develop that, however. I think one of the problems is that the only place that tried this, that I know of, is Ohio, and that was at the common pleas level of court in Ohio. One of the problems we have here is that we have a combined court with 100,000 landlord-tenant actions. I don't think you would propose that we merge those cases into a giant, individual calendar. I think there is some combination, some hybrid, that would work.

Judge MOULTRIE. We will talk about it. We will get together and talk about it.

Mr. POLANSKY. Our figures—and we have worked on this very carefully—now show that we would need 11 judges to meet our current needs, in addition to the 3 hearing commissioners that we have already been provided. That is to meet our current needs. Our best estimates are that, over the next year and a half, we will need at least four more judges to meet the increasing caseloads, and, if we were to attempt to knock down the backlog over a period of 3 years, it would take six additional judges.

The net of that is that we believe we could justify 21 judges at the present time.

Senator SPECTER. This is sounding more like a personal injury case all the time, a settlement demand for 21, and you will take 7. [Laughter.]

INDIVIDUAL JUDGE CALENDARING

Mr. POLANSKY. I would settle for seven, now.

Senator SPECTER. Chief Judge Moultrie, in 1970, I had lunch with Chief Justice Earl Warren shortly after he retired. He told me about the advantages of the individual judge calendar, and I went back to Philadelphia and sat down with President Judge Vincent A. Carroll, and I told Judge Carroll the tremendous advantages of the individual judge calendar, and Judge Carroll picked up the telephone and called Ed Blake, who was then the court administrator, now a judge.

Judge Carroll said, "Arlen Specter is here, and he has convinced me that we ought to go to the individual judge calendar. I want you to put that into effect," and he hung up the phone. And the next morning the order was rescinded. The judges were very resistant, the individual judges were very resistant to the individual judge calendar, because it puts everybody under a giant spotlight.

There is no reason why just the chief judge should be under a spotlight.

Judge MOULTRIE. Senator, in 1979 we instituted the individual judge calendar in the criminal—in the misdemeanor—section of our court, which we did not have before. So we are thinking along the same lines.

Senator SPECTER. I commend you for that. I think that is a good step forward, and what I am trying to do is help make Washington, D.C., the model.

Judge MOULTRIE. We appreciate that, sir.

Senator SPECTER. Because I think if there is to be a model in this country on a very decrepit, terrible criminal justice system, it is going to have to come out of Washington, D.C.

Judge MOULTRIE. Thank you.

Senator SPECTER. Thank you very much.

Mr. POLANSKY. Thank you, Senator.

[The statement follows:]

STATEMENT OF CHIEF JUDGE H. CARL MOULTRIE

As the court of general jurisdiction for the District of Columbia, the Superior Court is confronted with a complex and voluminous caseload. As of September 30, 1983, we had 2,061 serious felonies awaiting trial, which is a substantially larger number pending than there were at the end of September 1982. This is despite the fact that we have tried 511 felony cases through September of this year as compared with 419 cases tried through September of 1982 while disposing of 3,489 cases in 9 months of 1983 as compared to 2,972 cases in 9 months of 1982. Another troubling factor is that 1,284 or 62% of these pending felony cases are more than 180 days old from the date of indictment. In addition, another 988 felony cases are now awaiting either grand jury action or preliminary hearing resulting in a cumulative active serious felony caseload of 3,049 cases at September 30, 1982.

In our Misdemeanor program, there were 3,692 cases awaiting trial on September 30, 1983, again, significantly (15%) higher than the 3,197 pending one year ago. The number of misdemeanor cases filed through September of 1983 had reached 13,317 as compared with 12,287 through September of 1982. Our seven individual misdemeanor calendars have grown greatly this year and one of the calendars carried 617 cases at September 30th while the others averaged over 500 open cases each. A reduction in these individual calendar caseloads is absolutely necessary for we cannot expect judges to effectively and successfully handle and control loads of 500 and 600 cases.

Being mindful that each case represents critical matters in the lives of individual citizens and that disputes require timely resolution to obtain a truly just result, the elimination of court delay is clearly a major objective of our courts. Issues of delay have consumed much of our attention in the design of processes and procedures to make our trial court more efficient and we are proud of the innovation and achievement so far accomplished. For example, the D.C. Superior Court was one of only three courts in the nation recently selected by the American Bar Association to pilot a civil dispute resolution concept, the "multidoor courthouse". Under this program, individuals involved in certain civil disputes and, eventually, minor criminal and delinquency matters will be offered mediation or arbitration.

However, the level of workload now facing the District's courts represents a core of cases which cannot be accommodated by the mere reallocation of resources, the addition of a couple of law clerks or the revision of procedures. The Superior Court can only serve its citizens when it dispenses justice without delay. In order to try to keep up with the constantly increasing needs in the criminal division, we have shifted judges from other divisions which has, predictably, resulted in Family and Civil Division caseloads which are now reaching crisis proportion.

These cases require formal disposition by trial or the threat of trial. Their completion is conditioned upon the provision and availability of judges. There are times when the courts must perform their primary role, that of adjudication, and the tools necessary for the task of judging are judges. Therefore, we are requesting an increase in the size of the Superior Court Bench to 51 judges. This is in line with the number of judges originally proposed by the Senate during the reorganization of the District's courts in 1971 and most importantly, begins to approach the real need of the Superior Court.

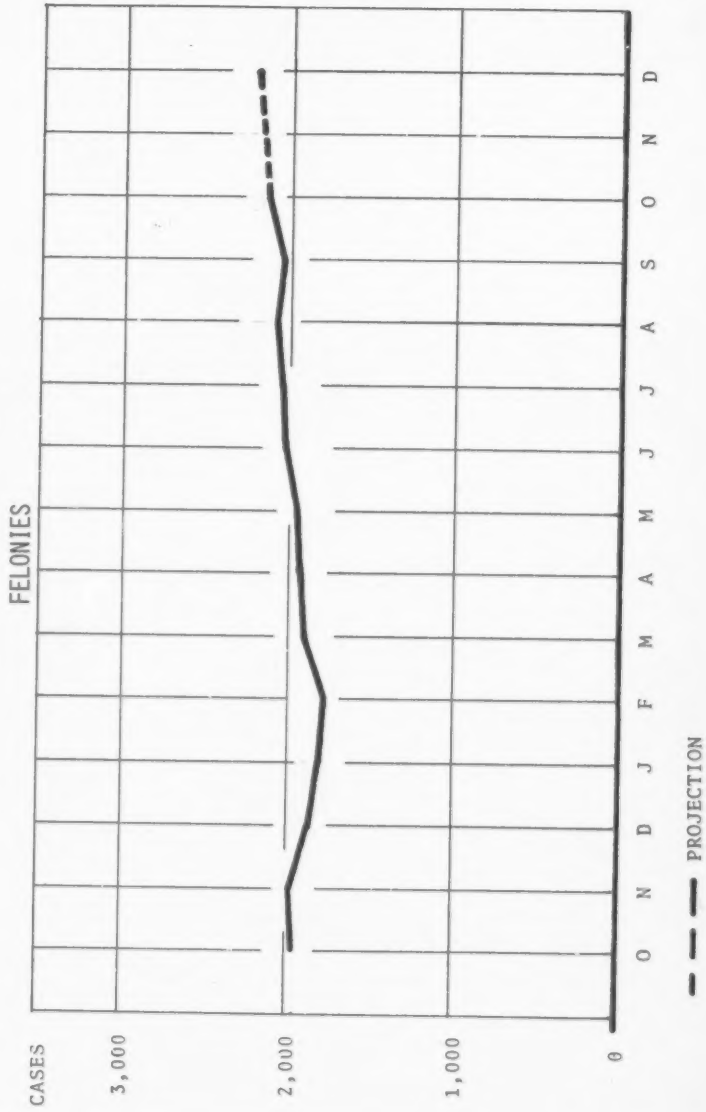
Factors that we have studied, such as, case filing projections, increasing pending caseloads and time between case filings and dispositions indicate a need for a minimum of 11 or more judges now (in addition to the three Hearing Commissioners already in place) to merely keep up with filings. This need increases to 15 judges by the end of 1984. If an assault on an unacceptably high pending caseload were to be launched, with the goal of reducing the backlog to an acceptable level by the end of 1986 (over a three-year period), an additional six judges would be needed.

The addition of the three Hearing Commissioners to the Superior Court has had a positive effect on the ability of the Court to reallocate existing judicial resources in critical areas. The program has been in effect for about one year and I can, without hesitation, recommend permanent Congressional authority to continue this program, but also can say for certain that there are limitations on the use of hearing commissioners.

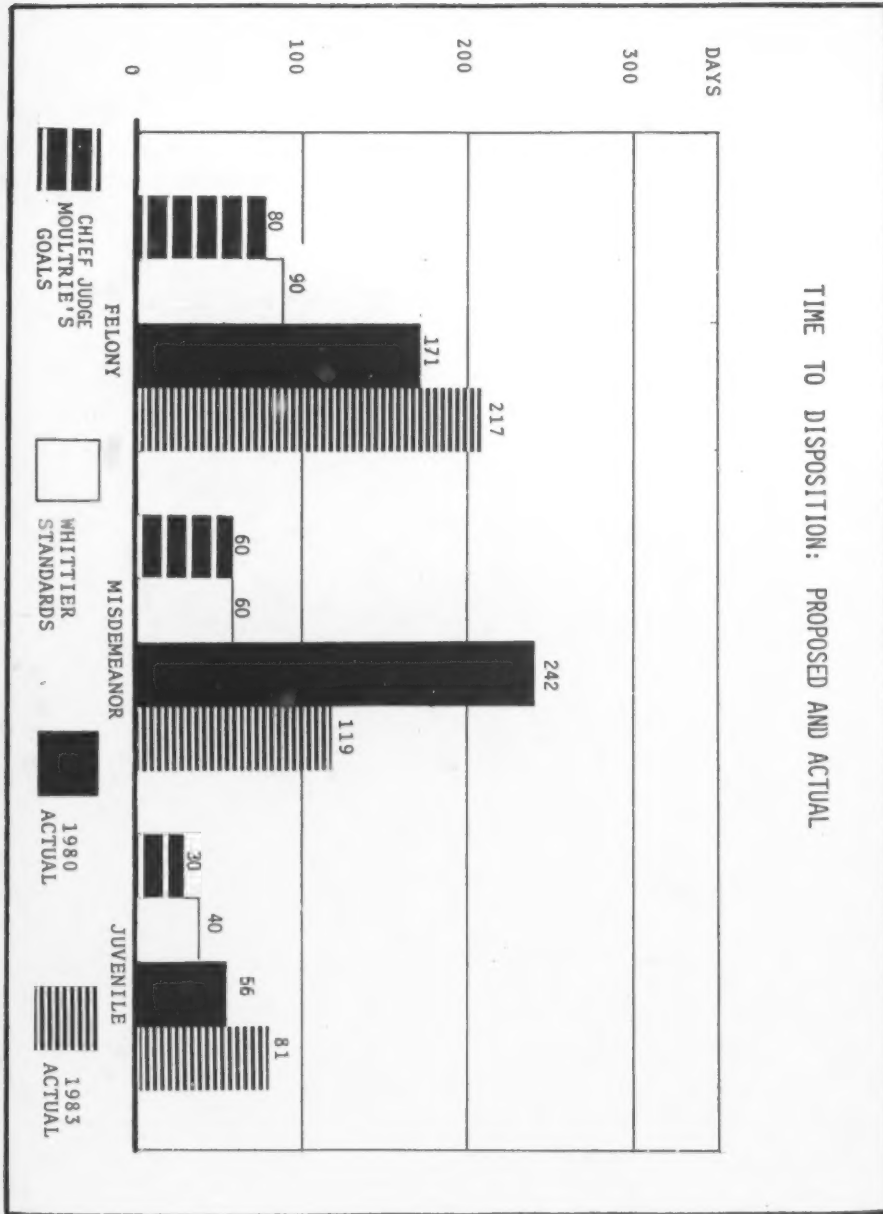
Congress and, particularly, Senator Specter's Committee, have voiced as priorities for the city: a maximum strength police force; additional U.S. Attorneys to impact on the crime problem; and increased legislative and program support to control the more serious offender. These measures call for a concomitant increase in judicial resources to meet these Congressional objectives.

On behalf of the citizens of the District of Columbia, and a Court which strives to serve its people well, I call for early non-partisan support in these matters.

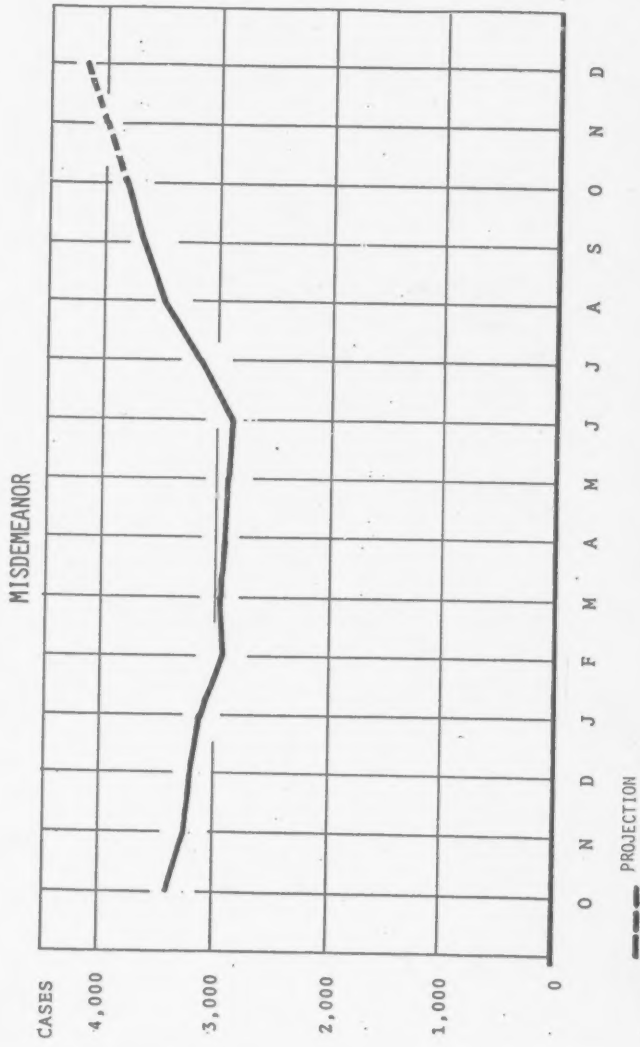
PENDING CASELOAD... END OF MONTH
OCTOBER 1982 THROUGH DECEMBER 1983



TIME TO DISPOSITION: PROPOSED AND ACTUAL



PENDING CASELOAD END OF MONTH
OCTOBER 1982 THROUGH DECEMBER 1983



HORSKY COMMITTEE REPORT RECOMMENDATIONS

CRIMINAL

MISDEMEANOR ----- 300 cases per Judge
max.



FELONY----- 100 cases per Judge
max.



CIVIL

CIVIL TRIALS----- "Considerable Resources
Required"



LANDLORD & TENANT----- "Seriously Inadequate
Resources"



FAMILY

JUVENILE----- "Too Few Judges"



DOMESTIC RELATIONS----- "Additional Full-Time Judge"



PROBATE, TAX, FIDUCIARY

PROBATE----- "Supplementary Nature No
Longer Appropriate"

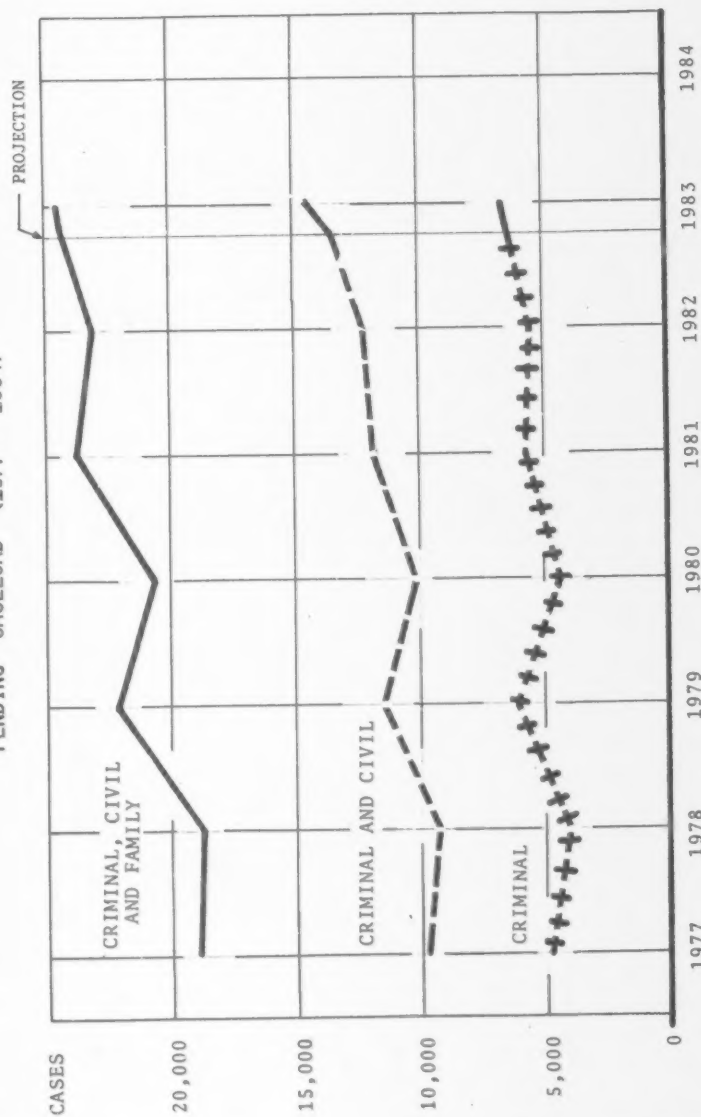


ADDITIONAL JUDGES REQUIRED----- 18

MANAGEMENT AND OPERATIONAL IMPROVEMENTS - D.C. SUPERIOR COURT

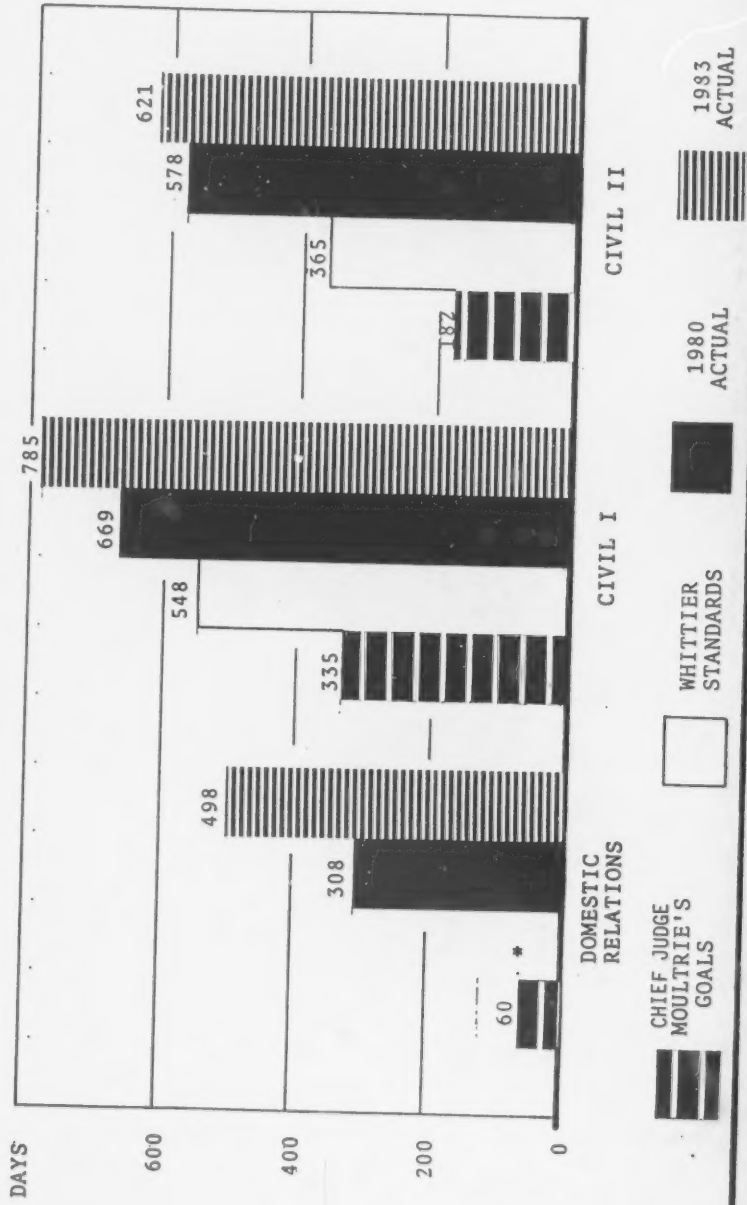
- Monitoring and Evaluation Systems
- Independent Analysis by Experts
- Assignment, Calendaring and Case Management Techniques
- Individual Calendars
- Reallocation of Existing Resources
- Use of Senior Judges and Hearing Commissioners
- Diversion and Alternative Dispute Resolution
- Updated Technology
- Cross-Training of Judges and Employees
- Refinement of Operations and Procedural Manuals
- Open Discovery with Tightened Time Limits
- Coordination with Justice Agencies
- Implementation of Model Probation System
- Streamlining of Presentence Reporting Procedures

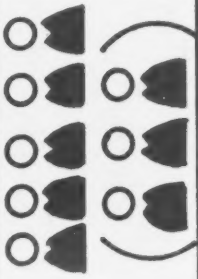
PENDING CASELOAD (1977 - 1984)



TIME TO DISPOSITION: PROPOSED AND ACTUAL

*No Comparable information available



JUDICIAL RESOURCES STUDY			
	CURRENT NEEDS	PROJECTED NEEDS	BACKLOG REDUCTION
CRIMINAL			
CIVIL			
FAMILY			
TOTAL	11 JUDGES	$\begin{array}{r} + 4 \text{ JUDGES} \\ \hline 15 \text{ JUDGES} \end{array}$	6 JUDGES

OFFICE OF THE BUDGET

STATEMENT OF BETSY REVEAL, DIRECTOR OF THE BUDGET FOR THE DISTRICT OF COLUMBIA

Senator SPECTER. I call the next witness, Betsy Reveal.

We welcome you back, Ms. Reveal. Thank you for joining us again today.

Ms. REVEAL. Thank you, Senator.

Mr. Chairman, I have a very brief written statement which I will submit for the record.

Senator SPECTER. Thank you.

[The statement follows:]

STATEMENT OF ELIZABETH C. REVEAL

Mr. Chairman, my name is Elizabeth Reveal and I am Director of the District of Columbia's Office of the Budget. I appreciate the opportunity to testify this morning concerning the issue of the D.C. Superior Court.

Let me begin my brief comments by thanking you again, on the Mayor's behalf, for the assistance and interest you have displayed since becoming chairman of this subcommittee. We are deeply appreciative of the time and effort that you have contributed and, in particular, of your involvement in the very serious criminal justice problems facing the District. Your willingness, not only to discuss and review these problems but also to seek additional resources in order to help us resolve them has been most welcome and we applaud your efforts.

We find ourselves, however, in a most awkward position with respect to the topic of today's hearing. The Mayor is sympathetic to the problems of the D.C. Superior Court and has, on numerous occasions, discussed that concern and a willingness to assist in finding remedies with Chief Judge Moultrie. We will continue to work closely with the bench in the near and the long term on these matters and to promote ongoing communication between the executive and judicial branches.

Nevertheless, we are unable at this time to firmly agree or disagree with the additional proposed judgeships. As you know, the District's elected representative, Congressman Walter E. Fauntroy, has publicly indicated his concern about the proposed authorization. Representative Mervyn M. Dymally, chairman of the Subcommittee on Judiciary and Education of the House District Committee and author of the legislation to transfer certain justice-related functions to the District, has expressed similar reservations. While we are grateful for the initiative you have shown on these matters, we must also take under serious consideration the concerns of our delegate and his colleagues. Therefore, we intend to work closely with the respective committees as the congressional review process proceeds and look forward to further dialog with you on the problems of the superior court and other criminal and civil justice administration in the District.

Again, thank you for the opportunity to appear and I would be happy to answer any questions that you might have.

SUMMARY OF STATEMENT

Ms. REVEAL. Let me simply summarize it for you. I want, on behalf of the Mayor, again to thank you very much for the interest in these matters that you have displayed since you have become chairman of the subcommittee. We are particularly appreciative of your concern about the criminal justice problems facing the District, and especially appreciative of your willingness to help seek resources in order to allow us to help resolve some of those problems.

NONCOMMITTAL ON AUTHORIZATION FOR ADDITIONAL JUDGESHIPS

We find ourselves today, however, in a fairly awkward position with respect to the topic of today's hearing. The Mayor is sympathetic to the problems of the D.C. Superior Court and has on numerous occasions discussed those problems with the chief judge and our willingness to assist in finding remedies to them. We intend to continue working, in the near and the long term, very closely with the chief judge and with the other members of the bench, and are extremely interested in insuring that there is close communication between the executive and the judicial branches.

Nevertheless, we find ourselves unable at this stage to firmly agree or disagree with the authorization of the additional judgeships.

As you know, our elected representative, Congressman Fauntroy, has publicly indicated his concern about the additional authorization. In addition, Representative Dymally, who chairs the Subcommittee on Judiciary and Education is the author of legislation that would transfer certain justice-related activities to this—

Senator SPECTER. That depends on who appoints the judges.

Ms. REVEAL. I beg your pardon?

Senator SPECTER. That turns on who appoints the judges.

Ms. REVEAL. And it also discusses prosecutorial authority; that's correct.

Senator SPECTER. Prosecutorial what?

Ms. REVEAL. Prosecutorial authority, transferring felony prosecution authority to the District.

Senator SPECTER. We are not going to solve that now—if we are to await the appointment of these seven new judges for that authorization, we will be waiting a very long time, it seems to me.

Ms. REVEAL. We are not suggesting, Senator, that the two are tied together legislatively at this time.

Senator SPECTER. What are you suggesting?

Ms. REVEAL. We are simply saying that in light of the fact that our delegate and his colleagues and others have expressed some reservations, the Mayor does not feel that we can affirmatively support—or oppose—these additional judgeships at this time, and we intend to work closely with the authorizing committees as this proceeds.

Senator SPECTER. Well, in that event, Ms. Reveal, your one-and-a-half-page statement is too long.

Ms. REVEAL. Then I am finished, Senator.

Senator SPECTER. OK. I thank you.

Ms. REVEAL. Thank you.

Senator SPECTER. Let's call on Francis D. Carter, the District's Public Defender, the Director of that system.

PUBLIC DEFENDER SERVICE

STATEMENT OF FRANCIS D. CARTER, DIRECTOR, PUBLIC DEFENDER SERVICE FOR THE DISTRICT OF COLUMBIA

Mr. CARTER. Good morning, Mr. Chairman.

Senator SPECTER. Mr. Carter, you have a few minutes to pound the table. You are a public defender——

Mr. CARTER. That is correct.

Senator SPECTER [continuing]. Of a system which has 1,600 people in custody, on a judicial system that is keeping them in jail for almost a year. What do you have to say for your clients who are being detained that long without being brought to trial, in light of the constitutional guarantee to a speedy trial?

Mr. CARTER. First, it intolerably hinders the ability of an attorney who prepares a defense, because for those persons——

Senator SPECTER. Aside from the attorneys who can't prepare a defense, what about these people sitting in jail for all this time?

Mr. CARTER. That is part of my response. It is extremely difficult for an attorney, first of all, to visit his client to talk about defense because of the large numbers of people who are now housed in the D.C. Jail. An attorney has an extremely long time to wait until he can see his client. It is added difficulty because the client is incapacitated to find——

DEFENDANTS ON TRIAL CHARGED WITH NEW VIOLENT CRIMES

Senator SPECTER. Mr. Polansky, before you go, and Chief Judge Moultrie; what statistics, what cases can you give me to illustrate the severity of this problem for public safety? There is not going to be a response on the line that we are on right now, the constitutional rights of those who are incarcerated. That is not going to make it happen.

What is going to make it happen is specifics of defendants on bail who are charged with new violent crimes. That will create a public concern like nothing else will.

Mr. POLANSKY. Senator, we will provide you with statistics showing the persons on bail.

Senator SPECTER. What I need beyond that is the specific cases, like the people who were arrested last week and what the charges are and how many pending charges they have on their records. That is the way to make it happen, and if you give me the facts and figures on the specific cases on what a defendant has been charged with in terms of the seriousness of an armed robbery or a rape or a homicide, when that defendant has been on bail for a length of time and the underlying charge for which he or she has been on bail, then we can start to focus the appropriate attention on the issue.

[The information follows:]

PERSONS ARRESTED OCTOBER 1987
 WITH PENDING CHARGES &/OR
 SIGNIFICANT CRIMINAL RECORD

THOMAS N. —		D.O.B.	2/07/46	
CHARGE	:	BURGLARY II	(11/16/83)	
PENDING OTHER CHARGES	:	BURGLARY II	(9/21/83)	
		(PENDING GRAND JURY)		
		POSSESSION HEROIN	(6/30/83)	
		(PENDING SENTENCE)		
		C DW	(6/4/83)	
		(AWAITING TRIAL BY JURY)		
HEALTH HISTORY/STATUS	:	GUNSHOT WOUND LEFT LEG		
		DRUG PROBLEM — HEROIN		
MICHAEL LEROY —		D.O.B.	2/23/54	
CHARGE	:	BURGLARY I	(11/17/83)	
PENDING OTHER CHARGES	:	UNLAWFUL ENTRY	(10/25/83)	
		(PENDING SENTENCE)		
PRIOR CONVICTIONS	:	BURGLARY II — INDIANA	(5/21/80)	
		BURGLARY II — PENNSYLVANIA	(11/9/80)	
		AGG. BURGLARY — OHIO	(4/11/77)	
		DRUG PARAPHERNALIA — MD.	(2/24/83)	
HEALTH HISTORY/STATUS	:	DRUG PROBLEM — COCAINE		

CHARLES DONNELL	D.O.B.	3/9/64
CHARGE	DISTRIBUTION P.O.P. MARIJUANA (11/17/83)	
PENDING OTHER CHARGES	ROBBERY (9/1/82)	
	(PENDING GRAND JURY)	
	BURGLARY II (6/9/83)	
	(AWAITING TRIAL)	
	ROBBERY (5/13/83)	
	(AWAITING TRIAL)	
PROBATION RECORD	09-28-72 ROBBERY/NO FINDING 6-28-73 01-28-73 SHOPLIFT/DISMISSED 05-14-73 SHOPLIFT/DISMISSED 07-19-73 GL/CLOSED JURIS TOT ANOTJER CASE 01-07-78 ROBBERY/NO PAPERED 02-02-78 ROBBERY/COMMITTED, TERMINATED 04-26 10-28-78 TWA/NO FINDING 09-20-80 ROBBERY/06-26-81/08-10-82 Probation 03-11-81 UE/DISMISSED 04-24-81 RSP/DISMISSED 05-27-81.	

SERVICES OF PRETRIAL SERVICES

MR. CARTER. You might find it informative, Mr. Chairman, to speak to the District of Columbia pretrial—

Senator SPECTER. Thank you very much, Chief Judge Moultrie, for coming. Thank you.

MR. CARTER [continuing]. The District of Columbia Pretrial Services Agency. It is my understanding that just about a year ago now, as a result of some funding they received from the Justice Department, they are studying the problem of persons rearrested while on bond. I am not sure if those figures are complete already for disclosure, but an inquiry to see at which stage their study is at the current time may be of some assistance in that area.

The Pretrial Services, as you may know, interviews everyone who comes into the court system, and checks their records and could find these statistics out. That may be of some assistance to you.

CASE OF WHITEFIELD GRAVES V. UNITED STATES

More importantly, the clash between the defendant's right to a speedy trial and, of course, the community's interest in its safety, is probably highlighted recently in a decision from the District of Columbia Court of Appeals in September, in the case of *Whitfield Graves v. United States*. There, the gentleman did not receive a trial until 24 months after his arrest. He was charged with first-degree murder. My office argued to the D.C.—

Senator SPECTER. And he was acquitted?

Mr. CARTER. No, he was convicted.

Senator SPECTER. He was convicted?

Mr. CARTER. He was convicted.

Senator SPECTER. There was one case recently celebrated where somebody was discharged because of the deprivation of the constitutional right to a speedy trial.

Mr. CARTER. That is the case, Mr. Chairman.

Senator SPECTER. That is the case.

Mr. CARTER. Whitfield Graves. It is my understanding that the full court will hear it en banc.

Senator SPECTER. But he was discharged?

Mr. CARTER. Well, he was—the final decision of the three-judge panel was that the case should be remanded, the conviction should be reversed, and the indictment dismissed for lack of speedy trial. That, of course, has been stayed pending en banc argument in front of the D.C. Court of Appeals. But that typically points out someone who has to wait in jail 24 months before coming to trial.

Senator SPECTER. And he was charged with murder?

Mr. CARTER. First-degree murder.

Senator SPECTER. And what were the facts of that case?

Mr. CARTER. My understanding is that he and two other gentlemen were alleged—

Senator SPECTER. Gentlemen?

Mr. CARTER. Excuse me?

Senator SPECTER. Gentlemen?

Mr. CARTER. This person—

Senator SPECTER. The presumption of innocence goes after a conviction, as the term "gentleman."

Mr. CARTER. Mr. Graves and two other persons were charged with, I believe, beating an individual to death, and were arrested and incarcerated and tried separately.

Senator SPECTER. A robbery beating?

Mr. CARTER. I believe so, sir.

Senator SPECTER. An elderly person?

Mr. CARTER. I am unsure at this time of the exact age of the deceased.

Senator SPECTER. Is Graves in custody now?

Mr. CARTER. Yes, he remains in custody.

Senator SPECTER. First-degree murder. Did he get a life sentence?

Mr. CARTER. Mandatory 20 to life under the District of Columbia Code.

I think, though, the tension between these two must be resolved in some way, and the issue you address today may be one of the factors that direly needs to be addressed. I think there are other things that can, of course, assist it. The system of diversion in the District is not as widespread as it should be for property, nonviolent offenses. And emphasis on disposing of cases before indictment, I think, has decreased a bit in our jurisdiction.

Nevertheless, the long delays in receiving trials for those defendants who desire them has gotten to really quite bad proportions.

Senator SPECTER. Thank you very much, Mr. Carter, for coming.

Mr. CARTER. Thank you, Mr. Chairman. .

SUBCOMMITTEE RECESS

Senator SPECTER. We very much appreciate your help. The subcommittee will stand in recess until next Tuesday when we will hear the Department of Corrections.

[Whereupon, at 10:55 a.m. Tuesday, November 8, the subcommittee was recessed to reconvene at 10 a.m. Tuesday, November 15.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1984

TUESDAY, NOVEMBER 15, 1983

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:06 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

DISTRICT OF COLUMBIA

DEPARTMENT OF CORRECTIONS

STATEMENT OF JAMES PALMER, DIRECTOR OF THE DEPARTMENT OF CORRECTIONS

ACCOMPANIED BY:

MICHAEL HAGSTAD, CHIEF, BUDGET, DATA, AND ANALYSIS
WILLIAM D. GOLIGHTLY, ASSISTANT DIRECTOR, ADMINISTRATION
BETSY REVEAL, DIRECTOR OF THE BUDGET
DR. OSA COFFEY, EXECUTIVE DIRECTOR OF CORRECTIONS EDUCATION ASSOCIATION
LARRY SOLOMON, ACTING DIRECTOR, NATIONAL INSTITUTE OF CORRECTIONS, DEPARTMENT OF JUSTICE

OPENING REMARKS OF SENATOR SPECTER

Senator SPECTER. Good morning, ladies and gentlemen.

We will commence this hearing of the District of Columbia Subcommittee of the Committee on Appropriations.

The purpose of this hearing is to have reports on, and suggestions for the action of the city on the use of \$22.3 million for the Department of Corrections, which was signed by President Reagan on October 12, on the District of Columbia Appropriations Bill. This has been a very substantial appropriation, and the subcommittee is very interested in monitoring the progress of the use of these funds.

We would like to know the specifics of how the funds are to be utilized, and what are the current estimates of future prison population and costs.

We have also called two outside experts to give an evaluation as to the appropriate use of these funds, from the point of view of the District of Columbia.

We are pleased today to have James Palmer, the Director of the Department of Corrections for the District of Columbia; Ms. Betsy Reveal, Director of the Budget, representing the city; Larry Solomon, Acting Director of the National Institute of Corrections with the Department of Justice; Dr. Osa Coffey, executive director of the Corrections Education Association.

There has also been some late breaking development as to the handling of certain sensitive documents by the Department of Corrections, where we had some interest and some inquiries to Director Palmer, and we will cover that, as well.

Mr. Palmer, Ms. Reveal, would you step forward and have chairs? We welcome you back.

Ms. Reveal was here as recently as last week.

We look forward to this ongoing relationship that this committee has as a matter of governmental oversight, and with the additional funds which we have made available to you, we are especially interested in seeing about their allocation, so that we can be in a position to show real accomplishment, and real progress for future appropriations, and as you know, for the point of seeing if we cannot make the District of Columbia viable, which can lead to additional appropriations on a nationwide basis.

PREPARED STATEMENT

Mr. Palmer, we have your statement. If you would begin by summarizing it, and giving us an update, we would very much appreciate it.

Mr. PALMER. Senator, good morning.

I would like to submit my statement for the record as it is.

Senator SPECTER. It will be admitted, without objection.

[The statement follows:]

STATEMENT OF JAMES F. PALMER

The D.C. Department of Corrections is faced with a serious challenge to its ability to successfully perform its mission because of historic high population levels, and increasing court pressures to relieve overcrowding and to improve the conditions of confinement. However, as a result of actions taken by this Subcommittee on our FY 1984 appropriation, we have been supplied with substantial resources to help the Department successfully meet this challenge.

Since passage of the Appropriations Act, the Department of Corrections and other District officials have been working to devise the most realistic and effective plan for use of the added funds and positions. The objectives are to control the current situation with regard to overcrowding, and to provide each inmate with the opportunity to achieve both basic literacy and a vocational skill prior to his release. I have made contacts with the D.C. Office of Personnel, the Department of General Services, and the Budget Office to establish implementation strategies, and to ensure that appropriate priorities are assigned to this program. I have involved my whole Department, including first-line staff, in developing the plan. D.C. Public Schools will provide support in recruitment, staff certification and program development.

While this process is still ongoing, the basic plan has been established. We are here today to present our proposal for implementation of the Criminal Justice Initiative, and to give the Committee a clearer idea of how we expect to carry out its mandate. The three major thrusts of the program itself are: first, inmate academic, vocational, and industrial training; second, classification, parole, and records officers for inmate processing; and third, security. This is consistent with the intent of the added appropriation.

I. Academic and Vocational Training.

Over half of the \$22.3 million allocation is planned for education services directed toward basic academic and vocational skills development, and industrial program expansion. S.A.T. results showed that 75% of the inmate population performs at or below a 6th grade level. Most inmates lack well-developed job skills. We plan significant staff and capital investments to upgrade the vocational program. One hundred and forty-two teachers and support personnel will be added. The District of Columbia Public Schools will assist in planning these basic skills programs. The currently available program space is not adequate to accommodate the proposed increase in program participants or staff in all facilities, even after using current facilities more extensively by adding evening and weekend classes. The following program building projects are required:

- . At the Central Facility, the current academic space will be doubled and four new fully-equipped vocational shops will be added, with offices. All academic program space will be air-conditioned.
- . At the Maximum Security Facility, five classrooms and two vocational shops are needed.
- . At Youth Center II, three new vocational shops, plus staff offices and equipment will be added.
- . Across the Lorton Reservation forty computer learning stations will be installed on a population/need basis.

The Industries Division of the Department of Corrections is a financially self-supporting operation. It supports all wages, supplies and equipment for its regular and inmate staff, as well as for non-industrial inmate wages. Its expansion will provide added employment for inmates. Benefits accrue to the inmate, who acquires work skills and attitudes, and to the Department, which has a larger portion of its population productively employed.

Expansion is expected in such areas as the garment shop -- producing uniforms for Police, Fire, and Corrections Departments employees; the print shop -- specializing in D.C. government agencies at a reduced cost; auto-body repair -- on D.C. government vehicles, and micro-fiche services for government records storage.

Funding of \$1.0 million will be used for start-up costs associated with each of these areas. Examples of start-up costs include training, equipment procurement and salaries of additional staff while the new programs reach full operation. Once started, these programs will become self-supporting.

A total of \$7.9 million in the capital program will be combined with \$5.1 million in academic, vocational, and industrial expansions. Overall, this program area receives the heaviest emphasis in our proposal.

II. Classification and Parole.

The increase of about 88 positions and \$1.6 million for Classification and Parole would provide for classification and parole officers, records staff, supervisors, and clerical support. Staffing was allotted to account for the projected population and to achieve workload ratio standards. The specific objective is to insure that no inmate who is eligible and ready for parole spends any additional time incarcerated just because progress reports or parole plans have not been processed due to a lack of staff. This will service to reduce current overcrowding.

Additional benefits are assumed. Classification and parole officers, working with more realistic caseloads will be able to spend more time in informal counseling and motivating prisoners to take part in programs, and to stay in them until successful completion. Parole officers should be able to pay additional attention to job development and counseling. The institutional

classification and parole officer increases will enable them to meet the requirements of the Twelve John Does Consent Decree covering the Orientation Unit and Diagnostic Unit. These staff include 51 classification and parole, 22 parole, and 15 record office staff.

Personal Services costs are projected to be \$1.6 million for an average of eight months on board this year. Supplies and equipment start-up costs are projected to be \$80,000.

III. Security.

The steady increase in population and consequent movement of the inmate population over recent years has placed an added burden on the security staff of the institutions. At least two court orders have specifically required increases in correctional officer staffing levels to meet the safety requirements of the inmates themselves. In a third case (Campbell vs. McGruder), added coverage was mandated in some areas without specifying a total number of officers to be provided.

The allocation of 115 staff and \$3.7 million to security functions will enhance public as well as institutional security. The addition should prevent further court intervention into this area. Proposed increases of 70 officers bring the Detention Center to a level that can adequately handle an additional 645 inmates, bringing the total capacity to 2,000. To expand Community Correctional Centers will require an additional 15 security staff.

Personal Services funding for 115 security staff and the annualization of 90 correctional officers, only partially funded in FY 1983, comes to \$4.0 million. Complete uniforms for this increased staff will cost in excess of \$100,000. Other supplies and materials costs come to \$94,000.

In addition to, and in support of the above programs, the Department plans to expand other inmate social services and

institutional services. Increases in these areas are dictated by recent population increases and the resultant workload expansion.

Additional psychologists, recreation specialists, chaplains and clerical support are needed to meet the basic emotional, physical and spiritual needs of the population, in the current seven institutions. In addition, halfway house counselors and community work program supervisors are needed to staff expansions in these areas.

The Department must provide for the basic services required for humane treatment. Other institutional services provided are a practical necessity or legal requirement. These services include medical, food, inmate finance, canteen and mail services. The workload in these areas is directly attributable to the population level. No staff increases have been funded in these areas, even as the population rose to its current overcrowded level, and services have deteriorated accordingly.

Inmate morale is especially sensitive to each of these areas. Appropriate staff augmentations in these areas will go far to facilitate the handling of the present overcrowded conditions.

A total of 77 staff and \$1.3 million in personal services funded, combined with \$120,000 in supplies and equipment will bring these support services up to the level appropriate for the current population anticipated in FY 1984.

Preliminary hiring and construction schedules suggest that, starting at once, the non-uniform staff can be on board by mid-June, and all correctional officers by the end of April. Construction of proposed new program space all should be completed by June 1984.

Monitoring and reporting on financial and program aspects of this plan are being given special attention. Routine reports on

the status and achievements of the program will be available throughout the year.

I wish to express my gratitude for the attention and sensitivity that has been shown by this Subcommittee to the extremely serious situation presently confronting the Department of Corrections. I am optimistic that, with this kind of cooperation between branches of Government, we can manage the situation successfully. I am personally committed to making this initiative work.

Thank you.

OUTLINING USE OF APPROPRIATED FUNDS

Mr. PALMER. All right.

Basically it is a statement outlining the use of the \$22.3 million, which we are extremely happy to get, and we hope to, in the later months of 1984, to come back to the committee and show them some wonderful results.

Basically what we are going to do in implementing the program, is to call on the Board of Education, particularly Dr. Floretta McKinsey and Dr. Labatt, who is the person in charge of the adult education program for the District of Columbia, to assist us in the implementation of this program so we can have a fast track, and start it sometime in January, so that we can have the proper certification, and so forth, to come before the committee in late July or August to show the progress that we will have made by then.

NUMBER OF INMATES NEEDING EDUCATIONAL SERVICES

Senator SPECTER. Director Palmer, when you take a look at the basic problem of releasing functional illiterates without vocational skill, do you have an estimate as to how many you have in your correctional institution at the present time?

Mr. PALMER. It is a breakdown that we have come up with, where we have probably about 75 percent.

Senator SPECTER. So that would be a total of how many?

Mr. PALMER. I would say maybe in the neighborhood of about 3,500 to 3,600, something like that.

ALLOCATION OF \$22.3 MILLION

Senator SPECTER. 3,500 to 3,600.

Now, how much of this \$22.3 million is going to be allocated to the aspect of correctional work, to try to teach literacy and some vocational training?

Mr. PALMER. The total operation will be roughly \$3.7 million. It will be roughly \$8 million in capital. And industries, of course, that will be approximately \$1.5 million; social services will be \$1.7 million. It will be in security, \$628,000—no, that is in social services, it will be under \$750,000, it will be \$4 million in security, and in institutional service it will be roughly \$900,000. That gives us a total of \$12,430,300 in operating funds, and it will be \$9,900,000 in capital funds.

Senator SPECTER. I see this category, academic vocational industries, \$8,222,000 for 216 positions.

Mr. PALMER. Those are the original proposals, Senator Specter.

CURRENT PROPOSAL FOR USE OF FUNDS

Senator SPECTER. What is the current proposal?

Mr. PALMER. Well, we have 142 academic vocational positions now.

Senator SPECTER. I see. I see. All right.

Mr. PALMER. What we did, we went into the institutions, we decided to do a study, so that we could have persons that we could program to get into the program itself. For example, we are trying to do this the same way we would do if we had a person who was out in the community working. We have people who we have in work programs, that we want them to continue in their work programs, some of them will be able to take classes in the daytime, and some will be able to take classes at night.

Senator SPECTER. Well, Director Palmer, you have changed the original proposal from \$8 million to the current proposal of \$4.5 million.

Frankly, that concerns me, that you are working with \$12,430,300. That is the total figure you are working with.

Mr. PALMER. Yes, sir.

Senator SPECTER. The original proposal that you had for academic/vocational/industries was \$8,222,800, and then you had correctional officers at \$3,720,000. Why is there an allocation for correctional officers at all, on what is basically a plan to teach literacy and vocational skills?

Mr. PALMER. Well, Senator Specter, unlike the world outside of an institution, we are going to have a situation where we will have approximately 10 persons that will be in the room with a teacher, and therefore we have to have security, and you know the problem—

Senator SPECTER. But you had to have security for these men and women before.

Mr. PALMER. Well, if we have security for them, but when we start breaking them out into classroom situations, we are going to put 10 people into a classroom, and we will have a problem with security, because we are going to have to bring teachers inside of the institution to teach.

Senator SPECTER. Where would those 10 inmates have been before? There would have been cost involved in their security prior to the time you put this program into effect.

Mr. PALMER. Well, they would, Senator, they would—some of them would be in cellblocks, so, for example, in maximum, some would be in cellblocks, the others would be in dormitories, where correctional officers are.

But once we segregate them, so to speak, and put them in classrooms, they will then be separate and apart, and a large number that we are going to have in classes.

Senator SPECTER. Well, Director Palmer, you know your business, I do not know your business, but I am concerned to see a figure of \$3,720,000 for correctional officers, and I am even more concerned to see the proposal to go up to \$4,144,800 on correctional officers.

And to see in this currently proposed figure only \$4,512,300 out of \$12,430,000. My request to you would be to go back, and you personally take a sharp eye to that figure, and see if we cannot see to it that more money goes into the ultimate purpose of vocational training and literacy training. Because that figure looks to me just to be too high.

Taking a look at another figure, what is encompassed within institutional services?

Mr. PALMER. Excuse me, Senator. Did you include the industries part into that? That would take it up to \$5 million something.

Senator SPECTER. Include the what?

Mr. PALMER. The industries program. If you look at that one—

Senator SPECTER. No; the industries program is \$1,122,500, but the total is \$4,512,300.

Mr. PALMER. Yes; and then we have the social services part of it.

Senator SPECTER. I am about to come to that.

MAKEUP OF INSTITUTION SERVICES

Looking down at that item, in Roman numeral V, institution services, what costs \$1,525,000, when it was not included in the original proposal?

Mr. PALMER. Senator, there are a number of chaplains included in this program, and a number of psychologists, also.

Senator SPECTER. Chaplains?

Mr. PALMER. Yes, sir. We have a number of chaplains, and a number of psychologists, that we have added.

Senator SPECTER. Well, why chaplains?

Mr. PALMER. Well, Senator Specter—

Senator SPECTER. Director Palmer, we are going to have to justify every dollar that is spent here. Psychiatrists, I have a doubt about, too. We are talking about teachers for reading and writing, and vocational training.

Now, if you are talking about psychiatrists, I can understand that that might be an ancillary or preliminary service, but, Mr. Palmer, we are going to have to put these dollars into teachers for literacy and vocational training, and I think we are going to have to really reshape these, to put these dollars right there, and the question I want answered is how many of these inmates are you going to be able to deal with?

I want to be able to come out—when you come back here for your budget request, 8 months from now, I want to know how much money you spend on how many people, and how many of them have been released, and how many of them have stayed out of trouble. Because that is the way you are going to get more money, and that is the way we are going to fund a realistic program for this country.

Mr. PALMER. Yes, sir.

IDENTIFICATION OF INMATES FOR PROGRAM

Senator SPECTER. How do you plan to go about it with respect to identifying the inmates who you are going to work on?

Mr. PALMER. We have had a survey of each institution, and we have come up with a number of persons we feel——

Senator SPECTER. How many have you come up with?

Mr. PALMER. It is exactly, Senator, 1,697.

Senator SPECTER. You are going to work on 1,600 to 1,700 men. Are these all men, or men and women?

Mr. PALMER. No, sir, these are all men.

Senator SPECTER. All men?

Mr. PALMER. Yes, sir.

Senator SPECTER. How about that? Are you going to include some women?

INCLUDING FEMALES IN PROGRAM

Mr. PALMER. The women that we have incarcerated are at mostly Federal institutions. We do have some at the jail, and we will have a limited program there. However, at the institutions we have some large numbers of persons who are illiterates. And therefore we——

Senator SPECTER. Women?

Mr. PALMER. Yes, sir. We have a large number, Senator.

Senator SPECTER. How many women do you have at the institutions under your control?

Mr. PALMER. As of this morning, we have 237, and that includes people awaiting bond.

Senator SPECTER. I think that it would be advisable to have part of this program applicable to women, at least on a proportional basis, because that would be a fair approach.

Mr. PALMER. Yes, sir.

Senator SPECTER. And if it is not done, somebody is going to ask why, and they are going to have a good point, if there is no application to women.

Mr. PALMER. Well, we do plan, Senator, to put some money into the program for the females. However, as I have stated, they are mostly in the Federal institutions, and they do get a program there.

Senator SPECTER. I appreciate that, and I think you would be justified in putting most of the money into men, but if you did it on a proportional basis, I think that would be an allocation that no one could disagree with, and it would give women a fair opportunity.

Mr. PALMER. Yes, sir.

Senator SPECTER. How long does it take to take an illiterate and teach him or her how to read and write?

Mr. PALMER. That is something, Senator, about which I am going to sit down and talk to Dr. Labatt. As you know, in an institution you have tremendous peer pressure on a person who cannot read and write. There is a certain amount of hostility that develops when you discuss it, and if you recall on your visit, which we were very happy about, some of the young people that you met who were functional illiterates, were persons who were very hostile. They were charged with very, very violent crimes.

APPEARANCE OF OTHER WITNESSES

Senator SPECTER. But, Director Palmer, let us bring some of our experts forward at this point, because we may be getting into some questions that they can help us with.

I would like Dr. Coffey and Mr. Solomon to step forward at this time, please.

Let us see, I do not know if we have enough microphones to go around. I do not know if we need them, really, it is a small room.

Dr. Coffey, Mr. Solomon, thank you very much for joining us.

The focus of our attention, as you have probably gathered, at this point, is this is a so-called oversight hearing by this subcommittee, as to how these funds are going to be spent.

We were able to get appropriations of \$22.3 million, which is a very substantial sum of money, even to the D.C. budget, and we have a twofold purpose in mind.

One is to do a job on the men and women in the D.C. corrections system, and the second is to use this as a pilot program, if we can show results, and get significant appropriations for the country at large.

And what this subcommittee is looking for is a practical program which we can put into operation as promptly as possible. We have the money at hand, right, Director Palmer?

Mr. PALMER. Yes, sir.

Senator SPECTER. Did you bring it with you?

Mr. PALMER. No, sir.

LENGTH OF TIME TO TRAIN AN ILLITERATE

Senator SPECTER. We have the money at hand to use, and if there was a question of how we apply ourselves, and I would like to direct it in the most expeditious manner that we could, for whatever short-term results can be demonstrated, but not at the expense of a sound program, or long-term results.

But the question which was on my mind when we asked you to step forward was how long does it take to train someone, if you can generalize, someone who is a functional illiterate? A stereotype, a person in Director Palmer's institution, 22 years old, probably a dropout from the 11th grade, maybe the 8th or 9th grade, probably not very academically inclined, lots of difficulties, can you generalize on it, Dr. Coffey?

Dr. COFFEY. I think it is a difficult question to answer, and if I were an adult educator, I would probably not try to answer at all. But from some of the research reports that I have seen in correctional programs, it is possible to get somebody raised in one grade level in approximately 2 to 3 months, with steady, every day good literacy training.

Senator SPECTER. One grade level every 2 to 3 months?

Dr. COFFEY. Yes; 2 to 3 months. That is about the best you can do.

Senator SPECTER. How long does it take to train someone? You learn to read and write by the time you are what, in the third grade? Fourth grade? I forget.

Dr. COFFEY. No; I think if you are really talking about some basic skills, on the first-grade level, but I also think that we should stress that most adult educators today are really kind of a little hesitant about talking about literacy per se, and prefer the term functional competency, which really does go beyond simply reading and writing.

Senator SPECTER. What does functional competency include, besides reading and writing?

Dr. COFFEY. It really includes the spectrum of social, personal, and economic skills that would make that person self-sufficient in managing, in his culture, and in his level of society. And that includes knowing how to handle transportation systems, and how to handle his money and taxes, and some rudiments of taking care of his children, and so on.

I went to Lorton not too long ago, and I talked to an inmate, who said, rather aggressively, as a matter of fact, he said, "Hey, just because I learned to read like a kid in the third grade, it does not mean that anybody is going to give me a job, does it."

It is a very hard question to answer. It does not mean that anybody is going to give him a job.

Senator SPECTER. What is the term that you just gave me?

Dr. COFFEY. Functional competency.

Senator SPECTER. Functional competency.

Dr. COFFEY. Some people still call it functional literacy, but literacy tends to make people think that it has to do with letters, and I do feel that this is something that we need to stress, particularly with adults who are learning to read and write, and so on.

ACHIEVING FUNCTIONAL COMPETENCY

Senator SPECTER. So functional competency would cover a variety of talents sufficient to get somebody a job?

Dr. COFFEY. Yes; I think that should be the goal of correction education with adult inmates in particular, to reach functional competency, before leaving the institution.

Senator SPECTER. Do you have a professional judgment as to how long that would take, on the average?

Dr. COFFEY. I do not think one can generalize, Senator, because it depends on—from where to where you are really taking people.

Senator SPECTER. Can you give me a range?

Dr. COFFEY. Well, I think I can give you the range, that there are, for example, some people, the estimate is up to 40 percent, who suffer from a variety of learning disabilities, handicaps, mental retardation, they are perhaps never going to be reaching quite the level that we are talking about.

We have other estimates that only about 10 percent of the inmate population already is at that level of functional competency.

Senator SPECTER. Ten percent are at that level?

Dr. COFFEY. At most.

Senator SPECTER. At most.

Dr. COFFEY. And 40 percent are probably handicapped, as defined under Public Law 94-142.

Senator SPECTER. Forty percent are handicapped?

Dr. COFFEY. Under the definition which is a very extended one in Public Law 94-142.

Senator SPECTER. Putting aside the question of those who are handicapped, what would your range be for a program to achieve functional competency?

Dr. COFFEY. Well, I think what you need is a wholistic approach, which means that you are not just teaching reading or writing. You are not just teaching a course in welding, but you are tackling the whole person. You are training life skills, social skills, values, as well as basic computation and literacy.

Senator SPECTER. All right. To do all that, what is the range of time?

Dr. COFFEY. I think, with some individuals, you might do a lot in a couple of years. Some people you might find, for example, a lot of people are very near a GED, or high school diploma, and you can do quite a bit in a few months. With others you are starting from scratch.

Senator SPECTER. You are talking what?

Dr. COFFEY. With a lot of the inmate population you are starting from scratch, and it is going to take time, and it is going to take money and expertise.

Senator SPECTER. How long, when you start from scratch, if somebody is well along, you might be able to do it in a few months? If somebody is somewhat further along, perhaps then 2 years.

You know, Director Palmer does not have all that much time with these people, either. The sentences that he has to work with are not that long.

When you get the longer sentences, you get a lot tougher kind of an inmate.

Dr. COFFEY. It is a question, Senator, that I do not feel that I can answer. I do not think anyone can honestly answer that. All I can say is that I do feel that one can do a lot given the resources, with what you have. Whether it is going to bring a person from total nonfunctioning competency to functional competency, during the period of incarceration, that is impossible to answer.

NATIONAL LEVEL OF FUNCTIONAL COMPETENCY

Senator SPECTER. What experiences are there on the national level, or anywhere in this country to achieve this functional competency, are there some correctional institutions which are undertaking it?

You were the executive director of the Corrections Education Association.

Dr. COFFEY. That is correct.

Senator SPECTER. Now, by that title, if anyone should know the answer to that question, you should. Do you?

Dr. COFFEY. I probably should, but I am not sure that it is a question that can be answered.

Senator SPECTER. Well, has any correctional institution in this country taken a look at its inmate population with a view to achieving functional competency?

Dr. COFFEY. Well, I think that several systems have that as a goal.

Senator SPECTER. Which ones?

Dr. COFFEY. Well, for example, the Texas Department of Corrections does use a system that is aiming at that. However, I think in Texas you have a conflict between a correctional philosophy that permits education only part time.

Senator SPECTER. Conflict on what?

Would you pull the microphone a little closer?

Dr. COFFEY. I am sorry. I say, for example, in Texas, from the educational viewpoint they are trying to implement a system that would do what we were talking about, make inmates achieve functional competency. However, as I feel personally that the philosophy of corrections in the State of Texas—

Senator SPECTER. Loss of what?

Dr. COFFEY. The philosophy of corrections itself creates almost a conflict with the goals of their position.

Senator SPECTER. What is their philosophy of corrections which creates that conflict?

Dr. COFFEY. The emphasis is really on work first, and then the education on the time that is left over.

Senator SPECTER. OK. Texas is not doing it right.

Who else is seeking functional competency, and is doing it right?

Dr. COFFEY. Well, I do think that most of the educators that I represent through the Corrections Education Association, would say that that is what we are all striving for. This is what correctional education is.

Senator SPECTER. Well, where has it been put into operation successfully?

Dr. COFFEY. Nowhere, if you are talking about any kind of ultimate success. There are bits and pieces. You will find a good program here, and a good program there.

Senator SPECTER. Where is there a good program?

Dr. COFFEY. To show you a good program in a bad institution, an old-fashioned one up in Minnesota, for example, at Stillwater, where

you have a wedding of all kinds of private and public resources, State moneys, Controlled Data moneys.

Senator SPECTER. A Minnesota institution called Stillwater, you say?

Dr. COFFEY. Yes; where they combine a prison industry program with a computer assisted instruction-free training program in life skills, and so on. There are programs, individual programs, that one can point to as good models.

However, even these good programs are dwindling under the current crunch for money.

Senator SPECTER. Director Palmer, you have a great opportunity here.

Mr. Palmer. Yes, sir.

Senator SPECTER. You have a great opportunity. You can write the book.

Mr. Palmer. We intend to, Senator.

Senator SPECTER. Where else is there a good program, Dr. Coffey?

Dr. COFFEY. Well, you have a very interesting vocational program in Georgia, that has been written up in several model program studies.

Senator SPECTER. Georgia?

Dr. COFFEY. In Georgia, which is a private vocational technology school, attached to the Departmental Correction with a contract, that inmates go out of the institution, and go there and train, sometimes to create what they call night owl programs, where inmates can use these better facilities, after ordinary school hours, in order to get more updated equipment, and so on.

I would personally be very happy to make available to the D.C. Department of Corrections the kind of information that my office has.

Senator SPECTER. Well, I wish you would.

If you were Director Palmer, and had \$22.3 million to spend, and had 3,000 inmates, identified 1,700 men, and perhaps 150 women, where would you start, if you were asked to show some results within a year? Do you know where?

USE OF COMPUTERS

Dr. COFFEY. Where would I start? I think I would start by putting some computers into the institution, because that is a very effective and quick way of doing it.

Senator SPECTER. Computers?

Dr. COFFEY. Yes, sir. That has proven to be very effective with inmates in terms of basic skills. The kind of things that takes constant drilling, and in studies that I have seen, the inmates do like computers, because it is not like the teachers that they disliked, and the people that they feel were reasons for dropping out of school, and so on.

It is a quick, effective way of starting. It does not do everything.

Senator SPECTER. But you would teach, you would teach the inmates by using computers?

Dr. COFFEY. To use computers, to train themselves in various areas. If you are putting a time limit on it, since I think your question is what will you do in a year. A lot of other things I think take much more

long range planning, when it comes to vocational programs. A year is a very short time.

Senator SPECTER. Is it unrealistic to look for some results within a year?

Dr. COFFEY. Well, I would have to ask what kind of results.

Senator SPECTER. The kind of results which I would be looking for would be taking some people in a prison population, given their limitations, and tackling those who cannot hold a job on the outside, we start with education, literacy, vocational training, we broaden the functional competency, as I think you probably do, and then within a year can you apply that money to turn out some people from Lorton who will be able to hold a job?

There is a very substantial sum of money which has been allocated, and the Congress will be asking a lot of hard questions, and it is going to be hard to come up with an appropriation next year, unless Dr. Palmer can come back here and be specific on what has been accomplished. That is what I am looking for.

Dr. COFFEY. Senator Specter, I do feel that that question is something I feel, maybe I am not speaking on behalf of my association, but kind of personally. I have worked with CETA programs in the past, and one of the problems that I see is that if you are expecting very quick results, you are going to find a certain amount of creaming going on.

You are going to take the inmates that are closest to giving you, on paper, the results you are looking for, and you are not necessarily reaching the ones that need the services the most.

Senator SPECTER. I incorporate in the question, if you can get short-term gain, and still have a solid long-term program. But if you are dealing with some creaming, that may be fine all by itself. It may be that a certain sum of money can be best used for people who are closest, and that is a good place to start. We should not neglect others, but that is a good place to start.

Dr. COFFEY. I always find a terrible dilemma about whether you want to put your money for those closest to the marketability in terms of jobs, or at the other end, for those who simply have not even started to read and write.

We have to, I think, create some kind of a balance between both.

Senator SPECTER. We are looking for two things. We are looking for a way to be helpful to the individuals who are in jail, and we are also looking for a way to protect society so that when they come out they do not commit more crimes.

Now, if you have 1,000 people in jail who may come out and commit more crimes, and you have x number of dollars which can make functional competency of 300 people at the top, as opposed to 100 people at the bottom, it would make sense to work on the 300 people at the top, because you would be providing public safety from 300 potential menaces, as opposed to 100 others.

So the program is not designed solely for uniformity and helping the inmates. That is part of it, but only part of it. And to the extent that

there is going to be a public reaction, a willingness to fund these programs, it is going to be on a public safety issue.

I believe in the program to help those who are there, but you will get the most response in a public context and in the Congress, on public safety, and that is what we should look to, as to what would really motivate the public to spend money.

Mr. Solomon, what suggestions would you have on the range of issues and questions?

PURPOSE OF THE CORRECTIONAL SYSTEM

Mr. SOLOMON. Well, I think Dr. Coffey covered them rather well. I think, as I was listening to the discussion, I guess the one question that came to mind here is really starting with what do we see the purpose of the correctional system. And I think that is a debate that has been raging now for about the last 5 years, with many people thinking that the prison system is not to rehabilitate or try to change behavior, because we do not even know what causes criminal behavior, and many of the problems transcend the correctional system, and start very early, and we are asking the Department of Corrections, within a very short period of time to change behavior, and there is really nothing more difficult than trying to do that.

But I think many correctional systems now are simply coming to the conclusion that the purpose of the system, the purpose of their correctional system, is not to try and rehabilitate, to try and change behavior, but to punish, or to incapacitate, and programs are often on a voluntary basis, not as a means of trying to change, you know, criminals into non-criminals, since we really do not know, in the first place, what contributes to that, and in the second place the problems around education and in work, how they are related are not clear.

And yet systems do continue to try and run programs, some of them are trying to rehabilitate, have not had good success, recidivism rates and other failure rates tend to indicate that.

And in the discussions here, I think that is a backdrop, that I think is important.

The only other thing that I think we are asking the Department here, in a very, very short period of time, to change what has taken years to—negative experiences with educational systems, with families and communities.

I am not suggesting that we do not try, but I think that context and that background is very, very important, to ask to do something, to accomplish something in a year, when we are not clear yet on what works, and I think that is what Dr. Coffey was getting at. It is a difficult task.

Senator SPECTER. When you say we are not clear on what works, it is unlikely that we are going to be clear on what works many years from now.

Mr. SOLOMON. I think what you were suggesting is interesting, and that is, there is no—this may be a good starting point. This may, in es-

sence, be kind of an experiment to try and figure out what programs work for what offenders, in trying to develop an approach using that means, trying to figure out what the needs are, studying the literature real quickly, and getting some assessment of what programs, what education, and what training, vocational education programs appear to work, and begin to put those in place, and then begin to study the effects of those programs.

Senator SPECTER. I appreciate what you say, in terms of the shifting attitudes on correctional institutions. And in dealing with problems as difficult as this, it is my opinion that there are no absolute answers, and that as we move forward in our experience we are going to have a whole new range of problems, and a whole new range of theories, and there is not going to be any concrete model that you could set out to achieve.

I have been in this field for more than 20 years, and started in 1960, going to Eastern State Penitentiary, as an Assistant District Attorney in the Parole Division, interviewing people for pardon applications, and on the parole issue, and I have seen the philosophy of rehabilitation come and be the highlight, and many people said there is no such thing as punishment, and it is barbaric to punish, we should only rehabilitate, and then the same people turned around and said this whole idea of rehabilitation is absurd, you cannot change people, we cannot figure it out, and we just incapacitate and separate. My own sense is that there are many who can be rehabilitated, many, many, many, and they ought to be given a chance for rehabilitation.

TWOFOLD PROGRAM

It is part of a twofold program, as I see it, and one part is to take juveniles, and to take first offenders, and second offenders, and have a constructive program, now defined in my lexicon as functional competency—I had not heard that term before this morning. I am pleased to have it. And that is only one-half of the issue.

The other half of the issue is that if people cannot move into programs which correctional institutions can offer, then I believe we have to impose life sentences on career criminals when they become third and fourth and fifth offenders, and I do not think it is appropriate, nor do I think a society can throw away the key, unless there is some way to give people an opportunity to work into the system, to become functionally competent.

I would like to see our criminal justice system move in both directions. First, it must move in a direction to provide some rehabilitation for those who cannot take it, and if they cannot take it, and they are going to be career criminals, then I think they have to be separated permanently. But the object is to come to grips with the matter, and define as best we can, some, at least, not all, but some, and the more the better.

Mr. SOLOMON. I think another thought too we are talking about here the time that they serve at the Lorton complex. I think we also have to

think that most of these people are going to get out on parole, conditional or nonconditional release, and there is the need to think about the followup in the community. Because you are talking about the time in the institution, you might have 1 year or 2 years, I think the average now is about 30 months of a person's time served, but they also spend many times an equal amount of time in the community on parole. And if you are thinking about developing programs, I think not only education, vocational work, placement, and so forth, so I think you have to think about all the time that they are within the custody of the Department of Corrections and develop your programs accordingly. There are many more resources in the community than there are in the institution. You can begin to hook them in the institution, hopefully provide the followup. Certainly you have them as a trapped audience in the institution, which is not the case in the community.

But I think when you think about using the \$22 million, whatever portion goes for vocational education, you have to think of a range of programs which extend into the community.

Senator SPECTER. Mr. Solomon, what is your background? What leads you to become acting director of the National Institute of Corrections?

Mr. SOLOMON. I was with the Massachusetts Department of Corrections as a deputy commissioner, with the D.C. Department of Corrections as a social service coordinator, worked in Anne Arundel County jail, and worked in social service area in the battered child area.

Senator SPECTER. You have been at that for how long?

Mr. SOLOMON. About 18 years now

Senator SPECTER. And what is your educational background?

Mr. SOLOMON. I have a bachelor's in criminology and a master's in psychiatric social work.

Senator SPECTER. Mr. Solomon, if you were Director Palmer and had \$22.3 million, how would you spend it, given the range of the problems that you would find?

Mr. SOLOMON. The Department of Corrections, are we talking about in the vocational education area, or across the board?

Senator SPECTER. Across the board.

OVERCROWDING OF JAIL AND PRISON PROGRAMS

Mr. SOLOMON. I think the most serious problem facing the Department of Corrections, as I understand it, is both jail and prison overcrowding, and we are talking about programs. It is hard to talk about developing any kind of programs when—in both instances you get 25 percent of the people at the jail who are to be sentenced and go to Lorton, as I understand it; you have incredible overcrowding problem at Lorton at the various components there. I think I would want to start focusing on seeing how I can bring that population down and developing some policy on who should be in prison, sentencing policy and policy on the use of my programs, both in jails and in prisons.

I think you have to put the context of talking about education and vocational education in the context of what it means to manage a crowded facility, which is what Director Palmer has to face every day. Right now he is spending probably more time in various matters of litigation than in trying to effectively manage a system.

My point is I think the one area that I would concentrate on would be to try to bring my population under control. That would be a matter of trying to work with the city government, the policymakers, developing sentencing policy here, then finding out the purpose of my prison, the purpose of my jail, and then begin to talk about within that purpose what type of programs I should offer depending upon the type of offenders that would be placed at the jail and sentenced to my prisons.

Senator SPECTER. Well, Director Palmer has some \$5,900,000 allocated for additional space. So he has that in the input. There has already been that division.

When you talk about the question of sentencing, of course you reach over into the courts, and I do not know that Director Palmer can influence that directly, but you are suggesting that he ought to do an analysis of whom he has. Perhaps he should not be having some of them in custody.

Mr. SOLOMON: I think that could be the case. We do not really know at this point.

Senator SPECTER. Director Palmer, do you have many in custody whom you think should not be there?

Mr. PALMER. I have not taken a serious look at that, Senator. I have so many that I have to worry about what we have.

FULL-TIME CRIMINAL JUSTICE COORDINATOR

Senator SPECTER. Well, there is an opportunity to do that. Right now we are discussing with Chief Judge Moultrie the issue of seven new judges, and that has reached a point of impasse on the home rule issue. And this may be negotiable to have some standards on the sentencing, which is an independent judicial prerogative. And the Parole Board is, I think, interested in restructuring its own standards. You really have a hard time asking Director Palmer to do all that, and what you really need is someone as a full-time criminal justice coordinator to take a look at all aspects of the city.

Ms. REVEAL, that comes to you. How about that? Is that something which ought to be done by the city with the management of this large sum of additional money?

Ms. REVEAL. I think we are approaching it in two ways.

We are obviously very cognizant of the combined problems of overcrowding, managing these facilities, responding to litigation and, at the same time, trying to demonstrate, as you pointed out, that there can be real improvement in terms of the educational standards and the job readiness of offenders that come out of the Lorton correctional system. I think that the caution that Larry has suggested in terms of how fast

we move and how much we can prove this year is well taken, but I think the Mayor feels very strongly that we can demonstrate some things. We are trying to work with the Department, as are several other of the Mayor's offices and agencies. We see this as an interagency effort that is heavily involved with our Department of Employment Services, the School Board, and in particular their adult education program and our Department of Human Services, along with the Department of Corrections.

PLAN TO IMPLEMENT PROGRAM

We have done two things from a central point of view to try and manage these combined problems and be able to demonstrate to you this year how the money has been spent and where we are going.

The first is to segregate the funds completely. So they are not simply in the Department's budget spread across all the expenditure categories in that budget. We have separately identified them even in our financial management system, and every penny will be tracked in terms of its expenditure for each of these items.

The second thing we are doing is working with the task force, including Mr. Palmer's department to try to review the proposed program and to try to work through with the Mayor and with the Director and his staff what the best use is and the quickest use is in terms of trying to get some educational program going quickly by January that takes into account some of the things that Dr. Coffey has mentioned.

PUTTING EDUCATIONAL PROGRAM IN PLACE

Senator SPECTER. An educational program in place by January?

Ms. REVEAL. We are trying and I think as Mr.——

Senator SPECTER. Are you ready for a visitor about January 24, Director Palmer?

Mr. PALMER. That sounds good.

Ms. REVEAL. I think that sounds very good.

Senator SPECTER. We will be back in session on the 23d, and Tuesday is the 24th. If you invite me, I will come.

Mr. PALMER. Yes, sir.

Ms. REVEAL. I think we would be delighted to do that.

The other part of this, Senator, is that the Mayor is extremely concerned about the vocational rehabilitation and about how that relates to our current industries program, what we are training offenders to do, and whether or not that training really is making them more functionally competent and more job ready, given the economy they are going to be coming back into in the District.

MAYOR'S COORDINATING COUNCIL

Senator SPECTER. How is the Mayor doing with his new Coordinating Council that he set up several weeks ago?

Ms. REVEAL. Two things have happened. One is the Mayor's Office of Policy and Program Evaluation is responsible for convening that group and for bringing them together. They in fact have the resources now to

do that, which have been identified. We have brought a person on-board to help us in that process. As you know, we also have an Office of Criminal Justice—

Senator SPECTER. Is that person a coordinator?

Ms. REVEAL. That person is going to be staffing the Council along with our Office of Criminal Justice Plans and Analysis.

As you know, we always had a local criminal justice planning agency in the city and it, at various times, played different roles with respect to interagency criminal justice coordinating bodies. There have been several of them. This latest is probably the most formal effort to really force these parties to—

Senator SPECTER. The issues raised by Mr. Solomon were very good ones and I really believe that they are beyond what you could expect Director Palmer to do.

I do not think he can really tackle that across the board, really require somebody who has the Mayor's direct clout, maybe somebody in your position, Ms. Reveal, who would cut across the lines of corrections, courts, and parole board. Not that the Mayor can control all those either because he cannot. He is dealing with independent agencies but he can be influential.

Ms. REVEAL. As you know, we not only view the budget as a financial management tool, but also as a program and policy tool. I think the way we approach the discussion of allocating our resources across those bodies is an important one.

As you know, in my last position I was Director of the Office of Criminal Justice Plans and Analysis for the city, and came back to this job. So it is very much a part of my own background and experience, and I think I tend to look at it a little more closely than some of the other areas, although we look at all of them.

INVOLVEMENT OF NATIONAL INSTITUTE OF CORRECTIONS

Senator SPECTER. Mr. Solomon, to what extent could the National Institute of Corrections become involved in assisting the Department of Corrections here with a view of substantial congressional interest, because Senator Thurmond is interested in what we are doing here, Senator Laxalt is, the chairman of the Criminal Justice Subcommittee, Senator Dole has been a major factor in the prison funding for some time. And I think that there will be similar interests on the House side so that it is broader than just saying would you help a city. You also live here?

Mr. SOLOMON. Yes; I have lived here most of my life too.

I think in a number of ways. As all of you are well aware, the purpose of the National Institute of Corrections is to provide technical assistance and training and information to units of State and local government. In the areas that we are talking about, we have some major initiatives underway in the area of prison industry and offer technical assistance and training in that area, and we can offer that to the Department of Corrections.

In the area of education, we are working with the Department of Education to get to the local level, State and local level, information on educational programs. We also, through our information center, have tremendous amount of information on what has taken place around the country in education, vocational training, prison industries, and can make that information available as well as technical assistance in those areas.

Senator SPECTER. So you could really give assistance to Director Palmer in how to tackle the problem overall in how to spend the money?

Mr. SOLOMON. That is correct.

Senator SPECTER. How about from the point of view of your organization, Dr. Coffey, would you be in a position to assist Director Palmer?

Dr. COFFEY. We are a professional association whose members represent the teachers and administrators of correction education. And what I think we have to offer is the fact that we have a network of professionals in this field with their expertise, and I can variously help link people in the District system with experts around the country who could be very helpful in setting up and planning some of these programs.

Senator SPECTER. And you will be willing to do that to assist Director Palmer?

Dr. COFFEY. We would be happy to do that.

Senator SPECTER. Because if you had good experience in Stillwater, Minn., or in Texas to the extent that they are there, or Georgia, no reason to reinvent the wheel.

Dr. COFFEY. We have many, many more like that. We also do keep a small clearinghouse on model programs that have been evaluated and we have some feedback on them. We can help again with program models that may work for Lorton as they might have worked in some other places. So on that kind of informal network linking, we would be very happy to assist.

Senator SPECTER. Dr. Coffey, what is your background that brings you to the position of Executive Director of the Corrections Education Association?

Dr. COFFEY. I am an educator who has worked with education for 25 years, starting with teaching junior high school, senior high school, college for 10 years, and then about 8 years ago got into corrections through education's research in corrections. I have spent the last 2 years before the position that I currently hold under a contract from the National Institute of Corrections to the Department of Education where I headed up the first corrections desk.

Senator SPECTER. And do you have a Ph. D.?

Dr. COFFEY. I have a Ph. D. in English literature, despite the accent.

Senator SPECTER. Where did you get your degree?

Dr. COFFEY. University of Maryland.

Senator SPECTER. And I notice a touch of Scandinavia in your voice.

Dr. COFFEY. Yes; I was born and raised in Sweden.

Senator SPECTER. Well, Sweden has good correctional facilities.

Dr. COFFEY. Chief Justice Burger likes it very much. He keeps going over there and looking and studying.

Senator SPECTER. What is it he likes very much?

Dr. COFFEY. I think he is always very interested in the prison industry aspect of Swedish corrections where we do have nowadays almost as a norm market level salaries.

The other thing I think he likes very much is that Sweden has a policy of incarcerating the fewest possible and treating the most in the community.

Senator SPECTER. The United States has the same policy, do we not?

Dr. COFFEY. I do not think the United States has implemented that policy.

Senator SPECTER. We articulate that policy. We may on a comparative basis incarcerate fewer than Sweden among those who need incarceration.

Dr. COFFEY. Well, the District of Columbia, according to latest statistics, incarcerates the highest in the world, 531.

Senator SPECTER. But there may be more in the United States who need incarcerating than need incarcerating in Sweden. I did not want to pick out the District.

Dr. COFFEY. No; I quite agree, sir. I think we do not yet have the kind of crime problems that this country does.

Senator SPECTER. When I was district attorney in Philadelphia, I visited the prosecutor in Stockholm in 1970, and I do not have a vivid recollection of what we found on comparative notes, but his criminal problems were much different than mine. Homogeneous population, very, very different, but I think we have a great deal to learn.

Dr. COFFEY. They are changing there rapidly. Sweden is getting much more like the United States in terms of not so homogeneous population, soaring crime, and drug problems.

Senator SPECTER. Well, I think this is really very helpful. It is helpful to me to see the facilities, expertise available from Mr. Solomon and Dr. Coffey, and they have made the offer to Director Palmer. And Ms. Reveal, I would appreciate if you would convey to the Mayor what we have done here today. I know you will. And taking my suggestion as to the coordination issue as to who on his staff, perhaps even you, might be a super czar, super coordinator of trying to cut across these problems. We would be willing to work with you and help you. The House is having hearings on the seven judges, as you know, at 9 o'clock on Thursday, and it does not appear now that we are going to be able to tie it all up in a knot by Friday if we adjourn, but I am going to stay with the issue. And in our discussions with Judge Moultrie, the Mayor has said he would identify things that he wanted to prove. And if there is somebody strong and competent within the executive branch, the Mayor's office, that would be a chance to cut across those lines.

Ms. REVEAL. I think the Office of Policy, which was created, was intended to do just that.

Senator SPECTER. Well, that is fine.

Who is the head of that?

Ms. REVEAL. My predecessor, Gladys Mack.

Senator SPECTER. I would like to have the chance to have her participation in our next hearing.

Ms. REVEAL. I will be delighted to do that.

Senator SPECTER. And, Director Palmer, I am going to come and see you, if you invite me, on the 24th.

Mr. PALMER. Yes, sir.

RETHINKING USE OF FUNDS

Senator SPECTER. And in the meantime I would like you to pursue the question that I raised about that chart, the money. I would like you to take a fine pencil to that, maybe after consultation with Mr. Solomon or Dr. Coffey, or both, as to how you could put the most money in the operational aspects, the functional aspects to achieve functional competency, because I just have a sense, and I could be wrong, but I have a sense that more could be allocated to the central nerve spot.

CLASSIFIED INFORMATION IN FILE CABINETS

Let me shift gears now that we have covered the topic of what is a matter of some interest, and that is the file cabinets, Director Palmer, which contain classified information.

Are those who work on file cabinets at Lorton cleared to handle top-secret governmental documents?

Mr. PALMER. No, sir, Senator, they are not, at this point cleared to handle them.

Senator SPECTER. Do you anticipate establishing a unit of functional competency within Lorton where there would be cabinet repairers who would have top-secret clearances?

Mr. PALMER. I doubt if we would be able to get that across at this point, listening to Dr. Coffey's testimony. I think that is something that we probably will have to examine in our program.

Senator SPECTER. What happened with the specific file cabinets, Director Palmer?

Mr. PALMER. What happened basically is that the file cabinets came into the institution and the documents were discovered, and we notified the State Department to come out and get them.

Senator SPECTER. They were State Department documents?

Mr. PALMER. Yes, sir.

Senator SPECTER. And were they classified?

Mr. PALMER. Yes, sir.

Senator SPECTER. Top secret?

Mr. PALMER. Yes, sir.

Senator SPECTER. And how many documents were there?

Mr. PALMER. I do not have the number, Senator Specter.

Senator SPECTER. Quite a number though?

Mr. PALMER. We moved them rapidly to the State Department and I was not cleared to read them.

Senator SPECTER. Were they returned to the State Department?

Mr. PALMER. They were returned to the State Department, some of them. And as you know now, the Federal Bureau of Investigation is heading up the investigation from the criminal aspect. And after some documents were turned over, some other documents were found and they were turned over to the Federal Bureau of Investigation.

Senator SPECTER. Were some of the documents found in the possession of inmates?

Mr. PALMER. Yes, sir. We have—

Senator SPECTER. How many file cabinets were involved here?

Mr. PALMER. I do not have the number of the file cabinets that were involved.

Senator SPECTER. Do you customarily at Lorton renovate, repair file cabinets? Is that one of the functions?

Mr. PALMER. We get quite a bit of furniture from the State Department and from other Federal Government agencies, and we normally repair and rehabilitate furniture.

Senator SPECTER. Well, what happened? Was it just a mistake made by the State Department in sending over cabinets which had these documents in them?

Mr. PALMER. I do not think I am qualified to speak for the State Department, Senator. I really do not know.

Senator SPECTER. All you know is that cabinets turned up at Lorton which had these documents in them?

Mr. PALMER. I know that it was reported that they had them in the cabinets that were brought over. The investigation is not complete on it.

Senator SPECTER. I suppose you have never faced—have you ever faced a situation like this before?

Mr. PALMER. Senator, I have faced some difficult situations in my 54 years of living, and having come to the Department of Corrections, I figure that nothing will change. My minister told me that he always thought I would go places but he never thought I would wind up into international politics. But the Department of Corrections is a very trying place. We live day by day.

Senator SPECTER. Well, I asked you the question from a line of whether you have any policies for taking a look at what comes in in Government file cabinets so that you might have some practice of taking a look preliminarily to see what somebody might be sending you by mistake.

NEW POLICY FOR INSPECTING INCOMING FURNITURE

Mr. PALMER. Oh, yes. We have a new policy and a directive that I will be signing shortly that will stop them at the entry point now.

Senator SPECTER. So that someone in a responsible position will be taking a look at the documents, at the file cabinets, the furniture, to be sure that there is nothing being placed in the hands of inmates which might be classified or cause some governmental problem?

Mr. PALMER. Oh, yes, we certainly will.

Senator SPECTER. And beyond that, the matter is in the hands of the Federal Bureau of Investigation. That is that.

Mr. PALMER. Yes, sir.

Senator, there is one bit of information that maybe we do have some people there who have some good minds. We did a little survey and we checked, and we have typewriters which have memory banks, and we found some documents on the memory banks. So——

Senator SPECTER. You found some of the documents in memory banks in Lorton?

Mr. PALMER. Yes. And we have turned those over. We have notified the FBI.

Senator SPECTER. I know you have Mr. Mike Hagstad with you.

Mr. PALMER. Yes, sir.

Senator SPECTER. Has Mr. Hagstad worked on this matter?

Mr. HAGSTAD. Not at all, sir.

Senator SPECTER. And you have Mr. Bill——

Mr. PALMER. Golightly.

Senator SPECTER. Have you worked on this matter?

Mr. GOLIGHTLY. No, sir, I have not.

Mr. PALMER. No one wants to be involved in this one, Senator. I cannot get any takers

Senator SPECTER. Well, I am sure you will be able to handle this one very well, Director Palmer. Those mistakes are made and it requires an investigation and the tracking of the documents and a retrieval of the documents.

Anybody in the institution that has gotten the documents and is making any inappropriate use of them, there certainly is a potential criminal violation involved which warrants the FBI's action.

Mr. PALMER. Yes; we have stepped up our efforts, you know, and the facilities, we have a large number of cellblocks. Some of them were found in the maximum institution, and we have 536 cells, and it is very difficult, Senator——

Senator SPECTER. You say you found them in 36 cellblocks?

Mr. PALMER. No, sir. I said we have 536 individual cells, and when you are looking for documents, you know it is very difficult. We have to get all the legal material and go through it page by page, and we have had a tremendous shakedown going on, night and day, over at the institution.

SHAKEDOWN AT LORTON

Senator SPECTER. How long has that been in process, the shakedown?

Mr. PALMER. We started the shakedown last week, and it has been fruitful. One inmate, when he saw that we were very serious about it, turned in some documents. So it has been fruitful.

Senator SPECTER. How much longer do you think it will take to complete the shakedown?

Mr. PALMER. We will be going quite awhile, Senator, because Lorton is a very large complex.

Senator SPECTER. When you make the inspections, do you need a search and seizure warrant to go into a jail cell?

Mr. PALMER. No, sir. I do not have to have a search and seizure warrant to go in. These are things that we do normally anyway. We have to shake the cellblocks down so that we can find out what is in them. So we do this periodically.

Senator SPECTER. You are customarily looking for something like narcotics or weapons, something which relates to the management of the institution as opposed to some document which might be illegally possessed. You have a little different kind of an issue there.

Of course, what you want to do is get the documents more fundamentally than an interest in prosecuting anybody for illegal possession.

Mr. PALMER. What we want to do is retrieve them, and also we have found in our shakedown that they had some other materials also. So what we did, we started out looking for two things. We have our normal shakedown, again it was just more intensified because we were beginning to look for paper.

Senator SPECTER. And in the course of the shakedown, you found not only the documents from the State Department but other documents, other materials as well?

Mr. PALMER. Yes, sir.

Senator SPECTER. Are you at liberty to say what kind of documents?

Mr. PALMER. They were material that was related to the institution itself. We found that an inmate had documents, that were related to the institution that I run, that he had no business in having. He was not cleared to have those either, but he had those also.

Senator SPECTER. Are some of those documents classified?

Mr. PALMER. No, sir. They are documents that should not be in his possession.

Senator SPECTER. Not classified in a national security sense but they are documents which he should not have, he or she should not have?

Mr. PALMER. Yes, sir, that is right.

Senator SPECTER. OK.

Well, that is a continuing problem that you have, Director Palmer. You have a challenging and difficult job and I think you are doing it well. And it is nice to have you come here from time to time, and we will be seeing more of you.

PREPARED STATEMENT

Dr. Coffey has submitted a prepared statement. We will insert it in the record prior to the conclusion of the hearing.

[The statement follows:]

STATEMENT OF DR. OSA D. COFFEY

I am Osa Coffey, Executive Director of the Correctional Education Association. I deeply appreciate this opportunity to bring before this distinguished committee some of the dire needs and problems of inmate education today. I further welcome this opportunity to ask your support for currently pending legislation which would assist in the alleviation of some of these needs by the provision of additional federal funds earmarked for an area neglected in other education or criminal justice legislation.

I understand the specific subject of today's hearings is a request for additional funds for the D.C. Department of Corrections, and that my testimony is intended to be a part of a backdrop, or a context, for the consideration of the D.C. request. Let the record show that I am in no position to comment on the D.C. request or to make any judgments on the D.C. Corrections System. I do believe, however, that my testimony is relevant to the crisis conditions prevailing here in the Nation's Capitol in the area of corrections. The District of Columbia has the highest incarceration rate in our nation (531 per 100,000) and a severe overcrowding problem, so it is more than likely that my generalizations about the educational needs of inmates and the lack of adequate programs to meet these needs are particularly applicable to the D.C. Corrections system.

I would also like to point out that I am personally acquainted with many of the education staff at Lorton, a group of very dedicated educators striving to serve their students against the odds created by overcrowding and lack of resources, that my remarks intend no criticism of the current educational staff or programs -- except that quantitatively they are not adequate to meet current needs.

Taking the broader view, which I was asked to do, I would like to suggest, as John Conrad has pointed out that:

"Apart from the criminal activity that brought the offenders to prison, the gap between present educational status and the potential for learning is the characteristic of the prison population that most characterizes it from the world outside the walls."

Only 10% of this population completed high school; 85% dropped out of school before their 16th birthday. Typically, inmates function about three grade levels below the grade completed. Some studies have indicated that as many as 32% display serious learning disabilities; 10% show incidence of mental retardation. It has been estimated that approximately 40% can be classified as "handicapped" under P.L. 94-142. Most state systems find that 20-30% of their inmates are functionally illiterate." (Conrad, 1981). The average unemployment rate for offenders prior to arrest is approximately 40% (as compared to the national average of 8%). Of those who were employed prior to arrest, 80% made less than a poverty level salary. (Coffey, 1981).

Since no agency maintains national data on either the educational status of prisoners nor on enrollment in education programs, the following information cannot be considered conclusive. However, if these figures are anywhere near accurate, they do suggest a tremendous gap between inmate need and available education programs. For example, Davidson (1977) studied juvenile correctional institutions in the state of North Carolina and found that 90% of the inmates in both adult and juvenile populations desired vocational education, yet only 9% actually received institutionally-based instruction. 34% of the population could not enroll in vocational education programs due to conflicts with work schedules. The Bell study found that 11% of the inmate body nationwide is enrolled in ABE programs; 12% in secondary GED programs. Carlson found that 12.5% of the 4,000 jails in the U.S. have any educational program at all. On an average, state correctional agencies spend about 1.5% of their total correctional budgets on inmate education.

If we look at the gap between inmate educational needs and current educational service delivery, one is tempted to agree with those who feel that education as a rehabilitative agent has not really been tried yet.

The cost of not meeting the educational needs of the incarcerated is very high, not only measured in wasted human lives, but in tax dollars. Lack of meaningful programs has proven to be a contributing factor in prison violence as well as riots, as testify the experience in Attica, New Mexico, and most recently Oklahoma.

But even more significantly, the cost of releasing inmates without the

tools for lawful survival — and 95% of all inmates do return to society at some time, on the average after three years — are staggering.

The consequences of failing to provide them with marketable skills are no secret and have been documented by The Education Commission of the States in a 1976 report that says, "it is obvious that to the extent that offenders cannot use knowledge and skills obtained from normal cultures to cope with normal society, they will use knowledge and skills obtained from deviant cultures to cope in whatever way they can."

Reincarceration is a costly and foolish alternative, if you consider that it takes on the average \$13,000 to keep an adult incarcerated for a year, and about \$60,000 in construction costs for every additional cell constructed in this country. As of July 1, 1982, the total operational budget for federal and state corrections was 6 billion dollars, not including planned and approved capital expenditures exceeding another billion and a half dollars. Furthermore, crime in America costs its citizens more than \$100 billion annually in direct and indirect losses, and confining prisoners costs \$12 million per day.

But do we really know that education and training programs can indeed reduce recidivism and increase the job opportunities and quality of life for ex-offenders and their families? Yes and no. The research necessary to demonstrate program effectiveness is sparse and lacking. The majority of existing research does not meet the standards of rigorous, scientific research and is descriptive rather than evaluative. However, isolated examples of good research do exist and they show that educational programs, when given adequate resources, rehabilitate many of these offenders and enhance their employability and self sufficiency. (National Advisory Council, 1981).

The most recent and perhaps most comprehensive assessment of the quality of vocational education programs in state prisons was conducted by Rice, Poe, Hawes and Nerden (1980). The purpose of this study was to discern, analyze, describe, and disseminate information about the critical variables that lead to the reduction of recidivism, increased in-program success, and increased post-release employment of adults in nine state prison vocational education programs (Rice et al., 1980). Exemplary programs were defined as those having acceptable success rates on two of three measures. These are:

1. Post-release employment rates of at least 60%,
2. Recidivism rates of less than 30%, and
3. In-program success rates of at least 70%.

Studies in Texas, Maryland, Oregon, and California indicate increased post-release success for inmates who were enrolled in post-secondary programs. A recent study from Ohio showed that the longer inmates are enrolled in vocational education programs while incarcerated, the more likely they are to succeed. I could give many more examples.

Before American corrections veered away from a rehabilitative orientation to the current emphasis on punishment alone, we had started to learn: What types of programs in what types of settings can be effective with what types of offenders? But never adequately funded, and currently severely threatened by dwindling monies coupled with overpopulation in our prisons, effective correctional education programs have been and are dying in their infancy, so to speak.

That leads us to the real problems we want to bring to your attention today and which were clearly identified in the NACVE hearings and subsequent report -- all of which suggest that vocational education and other rehabilitative programs have not failed but rather have never had sufficient resources to be effectively implemented.

The NACVE hearings revealed the following key problems:

1. Inadequate funding;
2. Lack of coordination in fiscal matters between state education and correctional agencies as well as on the federal level;
3. Lack of adequate facilities and equipment;
4. Inadequately trained teachers;
5. Lack of programs relevant to realistic job opportunities;
6. Lack of coordination with prison industries (See Appendix 1 for a summary of the NACVE findings).

Particularly stressed by many witnesses was the lack of a strong, defined federal role in this area.

At the time of the NACVE hearings, the Catalog of Federal Domestic Assistance listed approximately 70 federal programs through which funding for correctional educational and training activities could be obtained. However, no

ED programs are specifically designed or mandated to provide correctional education. Within the Department of Education, six Assistant Secretaryships are administering programs which provide funding, technical assistance, research and development and information dissemination services for correctional education. These include: Special Education and Rehabilitation Services, Bilingual Education, Vocational and Adult Education, Educational Research and Improvement, Post-Secondary Education, Elementary and Secondary Education.

Although correctional administrators may apply for funding under the programs administered by many ED offices, they must piece together information on authorizing legislation, program availability and eligibility, and the various rules and regulations which govern these programs, and somehow coordinate these efforts into a coherent programmatic package. Not surprisingly, then, correctional educators feel that the federal government could best address the needs of the field through providing leadership and coordination through a single office in the Department of Education as well as through a separate act such as that introduced by Senator Pell, S. 625, the Federal Correctional Education Assistance Act and its companion bill in the House, H.R. 3684, introduced by Congressman Conyers.

The lack of a federal policy delegating responsibility for correctional education and delineating cooperation and coordination among agencies at the federal, state, and local level was a severe handicap to the field until August, 1983, when Secretary T.H. Bell issued a United States Department of Education Policy Statement. I would like to quote just a few of Secretary Bell's words:

"These men and women who serve time in the criminal justice system are among those the Department of Education has a responsibility to serve. It is, therefore, the commitment of the Department to lend its efforts in upgrading and making more effective the educational programs in correctional institutions in the States.

It is, therefore, the policy of the Department of Education that through its leadership and resources: The Department will assist state and local jurisdictions to develop, expand, and improve their delivery systems for academic, vocational, technical, social, and other educational programs for juvenile and adult offenders in order to enhance their opportunities to become law-abiding, economically self-sufficient, and productive members of society." (The full statement is appended.)

I believe the policy, when implemented, could have a powerful effect in overcoming long-standing problems of confusion and frustration between the field and the federal/state levels. I agree with the philosophical and comprehensive nature of the policy. But I have a grave concern with the level of commitment as evidenced by the meager staff and budgetary allocations made by the Education Department to date.

I would, therefore, like to ask the members of this committee, not only to provide the District of Columbia with needed resources, but to take a broader view and provide Secretary Bell with the resources needed to carry out this federal policy on correctional education. In our judgement, and based on our experience that no, little, and inadequate monies filter down to correctional education when left up to the discretion of federal and state agencies, we strongly urge you to lend your support to S. 625, the Federal Correctional Education Assistance Act, as introduced by Senator Claiborne Pell.

We, the correctional educators, are not alone in realizing the dire need for more and better education programs in juvenile and adult correctional facilities. As is well known, Chief Justice Burger has repeatedly called for such programs in his major national addresses over many years. In his response to the NACVE report and its recommendations, the Chief Justice wrote:

"One small but practical, positive step - indeed, a step that I have advocated for many years is the introduction of mandatory educational and vocational programs for all inmates. No one should leave prison without at least being able to read, write, do basic arithmetic and be trained in a marketable job skill. Unless we accept the hard reality that the confinement of offenders behind walls and bars -- without trying to change them -- defeats a principal objective of the penal system, we will never make any progress in the battle against crime. This is not a visionary idea but a common sense application of the concept of society's collective self-interest."

Mr. Chairman, I thank you again for this opportunity to address this distinguished Committee on behalf of my fellow correctional educators.

[APPENDIX 1]

VOCATIONAL EDUCATION IN CORRECTIONAL INSTITUTIONS

RECOMMENDATIONS

The National Advisory Council on Vocational Education received information as a result of four national hearings from individuals representing a broad spectrum of interests in and concerns about vocational education conducted by correctional institutions. Based on this information, the Council, in preparing its recommendations, recognizes that vocational education must contribute to and work in harmony with the total range of corrections education and other services to ensure the full development of the students' interests and talents.

The recommendations which follow provide direction for fundamental changes and new leadership roles by agencies to help prepare offenders to become productive workers and tax paying citizens. The Council's concerns are, however, not limited to these seven recommendations. We encourage other agencies to use the different ideas and recommendations presented by witnesses and found in this Report. To illustrate, the Federal Bureau of Prisons would want to examine the age limitations imposed on prospective teachers by Federal law or, the U.S. Department of Education in cooperation with the Department of Labor expand the Apprenticeship model essentially used in Federal prisons to more state programs and local programs or service deliverers. Other Federal and State agencies, including the U.S. Department of Justice and the state departments of corrections, will find pertinent information in this Report which should cause them to become more active in helping improve corrections education and occupational training programs and services.

The Council recommends --

That Congress:

- Acknowledge the need for a comprehensive instructional program (including vocational education) with support services by establishing through legislation an adequately funded Correctional Education Program.

Coordination at the state level of existing resources from other programs for use in correctional education should be required.

- Specify the corrections population - juvenile and adult offenders - in vocational education legislation as a primary group to receive Federal support.

Federal funds for services to this population should be administered by a state educational agency.

- Make available to states special financial resources which would be allotted to local programs that demonstrated successful efforts in such areas as the improvement through innovation of correctional vocational programs and outreach to and working relationships with community resources. The coordination of prison industries with the educational and training needs of students is absolutely essential.
- Require a description of local program operations as a condition precedent for receiving Federal funds to implement comprehensive vocational programs for male and female juvenile and adult offenders.

The program description would include: (a) planning programs including the use of standards and of an appropriate advisory committee; (b) implementing programs including the involvement with remedial, adult, and other educational programs; (c) evaluating programs, and; (d) reporting on and using results from evaluations.

That U.S. Department of Education:

- Establish a corrections unit with full time staff.

The unit should provide coordination services, technical assistance to and be a clearinghouse for the corrections field and governmental agencies. Among its responsibilities should be the development of standards and initiation of evaluations of correctional vocational education programs conducted by juvenile institutions, jails, and state and federal prisons. Such standards and evaluations would be compatible with and contribute to the overall corrections education system. Further, the Council believes that the standards be developed by a process undertaken in cooperation with a special panel or task force. Membership on this panel should be formed from such organizations as the National Institute of Corrections, National Institute of Education, Federal Bureau of Prisons, American Vocational Association, American Correctional Association, Correctional Education Association, community-based organizations, business and labor groups, and relevant advisory committees.

That State Education Agencies:

- Require a craft or program advisory committee, which has a majority of private sector representatives from industry and labor, for each local institution or agency receiving Federal aid for correctional vocational education.

This committee should provide technical assistance for developing job readiness and job occupational skills through an appropriate curriculum; for identifying emerging or demand occupations where employment opportunities are available; and for evaluating the program including student job placement and staff development for security and educational personnel.

That State Advisory Councils on Vocational Education:

- Investigate through their State attorney general's office and other sources the state's laws/regulations that restrict offenders and exoffenders from "free world" employment in order to make recommendations for abatement to state legislative agencies.

EXECUTIVE SUMMARY

Within the past decade there has been a growing concern on the part of some members of Congress and the Executive Branch, correctional administrators, and the informed public about soaring crime rates, overcrowded, substandard, and violence-ridden correctional facilities, and the seeming failure of current rehabilitative practices, as evidenced by high recidivism rates and massive unemployment among ex-offenders. Analysis of public opinion also suggests that there is diminishing confidence in the system's ability to habilitate inmates. The public's attitude seems to be "...that anyone sent to prison does not deserve the opportunity to be rehabilitated."

Based on this growing concern and the general public's negative attitude, the National Advisory Council on Vocational Education (NACVE) decided, in 1979, to hold hearings as part of a study of correctional vocational education in the United States. From November of that year to April of the next, the Council conducted four national hearings on the "status of vocational education in correctional institutions" and received wide-ranging testimony from 106 witnesses representing 27 different states. By making correctional vocational education a priority for the year, the

Council fulfilled part of its very broad mandate to advise the President, Congress, and the Administration on matters concerning vocational education and its administration.

OVERVIEW

Approximately 446,000 adults are at present incarcerated in the nation's 912 state correctional facilities, 4,000 local jails, and 49 federal institutions and centers. Fifty-nine percent of all adult inmates are in state prisons, 36 percent in jails, and the remaining five percent (or 24,000 inmates) in the federal prison system. Incarceration has dramatically increased during the last decade. Between 1973 and 1978 there was a fifty percent increase in the incarceration rate for adult offenders. Ninety-five percent of all those who are incarcerated will eventually return to the free world; approximately 150,000 inmates are released each year. Those released should have received quality, comprehensive vocational preparation prior to their reentry into the free world and subsequent participation in the labor market.

There is a good deal of support for the view that vocational and educational programs, given the appropriate resources, can promote positive change in individual inmates and enhance their chances of obtaining jobs upon release and becoming productive members of society. Warren E. Burger, Chief Justice of the U.S. Supreme Court, advocated in his 1981 report to the American Bar Association, that vocational and educational programs be made mandatory, with credit against the sentence given for education progress. Two former offenders stated that successful completion of one vocational course may be the first real accomplishment for an inmate and thus a source of inspiration leading to rehabilitation.

Vocational education in corrections can be defined as instruction offered through the systems (i.e., jails, state and federal prisons) to enable offenders to be employment-ready upon their return to free society. It involves the development of basic skills, specific occupational training, and an array of "job readiness" attitudes and talents, including the development of positive motivation, good work habits, and survival skills. By using this definition as a guideline, the hearings brought forth a general understanding of vocational programming as it is practiced in correctional institutions. Overall, the current level and quality of correctional vocational education is not adequate enough to provide, on a regular basis, comprehensive vocational education programs to offenders. As a result, when offenders return to society, they are not prepared to compete in its labor market. The tone of the testimony was that the problems and barriers hindering the efficient and effective delivery of vocational education are not insurmountable. Goals and efforts to bring about change must not be timid.

Specific Findings

Over the course of the four hearings several issues were addressed repeatedly. Four major issues were implicated in all the problems, frustrations, and possible solutions discussed by the witnesses. What follows is a listing of some of the problems and some of the related recommendations (expressed as observations in the last section of the report) identified by the witnesses for each of the four major issues.

Funding:

- Inadequate funding.

Congress should include in the VEA reauthorization language and policy assuring correctional programs access to funding and services under all provisions of the Act.

- Lack of cooperation and communication, including fiscal matters between state education and correctional agencies.

Congress, through the VEA reauthorization, should consider, or mandate, the establishment of a staff position for correctional education in each State Department of Education which would help link the many state resources and agencies that assist education and employment training.

Federal vocational education legislation should specify and encourage formal communication on the state level between the State Department of Corrections and the State Department of Education and other agencies involved in providing services to offenders.

Administration:

- Insufficient recruitment, training, and retention of qualified vocational instructors.

The Federal Government should encourage quality programs and curricula for the training of correctional teachers and staff for academic and vocational programs.

- Lack of adequate facilities and equipment.

Federal funds, either through the VEA or additional legislation, should be made available to upgrade and expand existing facilities and equipment used in correctional vocational education.

- Lack of coordination and integration of vocational programs with prison industries.

Congress should consider amending VEA to ensure that prison industries are coordinated and consistent with the educational and training needs of inmates.

Comprehensive Programming:

- Lack of vocational program standards at all levels.

The Federal Government, through NACVE or other appropriate agencies, should develop national minimum standards for educational and vocational programs in correctional institutions.

- Lack of programs relevant to realistic job opportunities.

The Federal Government should encourage further involvement on the part of industry and labor in correctional education by requiring state advisory committees on correctional education with broad representation, including that of the private sector.

Federal Policy and Leadership:

- Absence of overall coordination.

The U.S. Department of Education should establish an office for Correctional Education.

- Shortage of research, evaluation, data collection, and technical assistance.

The Federal Government should assume a leading role in promoting and supporting much needed research, evaluation, and data collection in correctional education.

Congress should provide funding for and charge the Department of Education with the responsibility to establish a national information, research, and reporting system for education and vocational training in correctional facilities.

[APPENDIX 2]

U.S. DEPARTMENT OF EDUCATION CORRECTIONAL EDUCATION POLICY STATEMENT

The Department of Education, under the direction of the Secretary of Education, is legislatively designated as the primary agency responsible for the administration of Federal programs of financial assistance to education. The Secretary is authorized, upon request, to provide technical assistance to State educational agencies, institutions of higher education, local school systems, and other instrumentalities of the States.

The Department's programs and budget are focused on two essential goals:

- to guarantee that students of all ages enrolled in our schools, colleges, and vocational centers have equal access to the best possible education; and,
- to improve the quality of education for every student by supporting research, development, and dissemination of new teaching methods and materials.

Education is a necessity for every American, including the more than 2.2 million adults and juveniles who are under the jurisdiction of the criminal justice system. However, few of the nations jails provide educational services. Most of the nations prisons provide basic academic and vocational programs, but fewer than 12 percent of the total prison population have access to such programs.

The men and women who serve time in the criminal justice system are among those the Department of Education has a responsibility to serve. It is, therefore, the commitment of the Department to lend its efforts in

upgrading and making more effective the educational programs in correctional institutions of the States.

The Department's involvement in correctional education is further justified by the extreme level of educational disadvantage found in the corrections population. By advocating improvement in the quality and quantity of education and training opportunities for adult and juvenile offenders, the Department of Education will redress this educational disadvantage found in the corrections population.

Compared to other educationally disadvantaged groups, the social and economic cost of the corrections population is extremely high. The criminal justice system places a heavy burden on the American taxpayer. Custody costs range from \$13,000 to \$40,000 per inmate each year. Also added to that are court costs, welfare payments, construction costs, and a host of other costs commonly associated with arrest, conviction, incarceration, release, arrest, and reincarceration.

At the current rate of recidivism, it is estimated that of the 150,000 inmates who will be released this year, between 30 to 70 percent will be recommitted to a correctional facility within one year. Lack of basic education and marketable job skills aggravate a released offender's difficulties in securing employment, thus, influencing the return to crime. However, with the tools for survival--basic education and a marketable job skill, coupled with the rise in self-esteem which is the inevitable result of achievement--a released inmate's chances for rehabilitation are considerably increased.

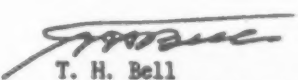
It is, therefore, the policy of the Department of Education that through its leadership and resources:

- o The Department will assist state and local jurisdictions to develop, expand, and improve their delivery systems for academic, vocational, technical, social and other educational programs for juvenile and adult offenders in order to enhance their opportunities to become law-abiding, economically self-sufficient, and productive members of society.

To carry out this policy:

- o The Office of Vocational and Adult Education will assume leadership for the Department's Correctional Education effort.
- o The Department will establish an intra-departmental coordinating committee on Correctional Education to assist in bringing about greater cooperation and coordination in the Department's corrections-related programs in the areas of policy, use of existing resources, avoiding duplication of efforts and costs, and effecting a better delivery system for needed services at the State and local levels.
- o The Department will play an active role in interagency corrections coordination activities.
- o The Department will support research, development, and dissemination efforts to develop knowledge of special curricula, organization, personnel, and support services needed in correctional education.

All officers in the Department of Education and all State and local educational agencies receiving the Department's assistance are encouraged to act in accordance with this policy.



T. H. Bell

Secretary of Education

AUG 16 1983

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CONCLUSION OF HEARINGS

Senator SPECTER. Thank you all very much, and the hearing is concluded. Thank you.

Mr. PALMER. Senator, thank you very much, and I was happy to see you on the television. And although the Phillies lost the ball game, I was very happy to see you that night.

Senator SPECTER. Thank you. Wait until next year.

[Whereupon, at 11:14 a.m., Tuesday, November 15, the hearings were concluded and the subcommittee was recessed to reconvene at the call of the Chair.]

LIST OF WITNESSES, COMMUNICATIONS, AND PREPARED STATEMENTS

	Page
American Psychiatric Association, prepared statement.....	210
Bowsher, Charles A., Comptroller General of the United States, letter from.....	205
Carter, Francis, Director, Public Defender Service.....	247, 326
Coffey, Dr. Osa, Executive Director of Corrections Education Association.....	331
Prepared statement.....	360
Dellums, Hon. Robert V., U.S. Representative from California, letter from.....	206
DiGenova, Joseph E., Principal Assistant U.S. Attorney.....	23, 257
Dixkoskoff, Karen, Esq., vice president, Superior Court Trial Lawyers Association.....	224
Downs, Thomas, City Administrator, District of Columbia.....	1
Prepared statement.....	19
English, Mike, Acting Budget Officer, St. Elizabeths Hospital.....	47
Fauntroy, Hon. Walter E., Delegate, District of Columbia, letter from.....	205
Ferrell, H. Albion, D.C. Board of Parole.....	23, 257
Galiber, Yetta W., executive director, Information Center for Handicapped Individuals, Inc., prepared statement.....	202
Gibson, John, D.C. Board of Parole.....	23, 257
Golightly, William, Assistant Director for Administration, Department of Corrections, District of Columbia.....	1, 331
Hagstad, Michael, Chief, Budget, Data, and Analysis, Department of Corrections, District of Columbia.....	331
Harris, Stanley, U.S. Attorney for the District of Columbia.....	23, 257
Prepared statement.....	262
Holland, George, Assistant Director for Detention Services, Department of Corrections, District of Columbia.....	1
Isbell, David, president, District of Columbia Bar Association.....	251
Ittala, Tony, Deputy Assistant Secretary for Budget, Department of Health and Human Services.....	47
Just, Bernice, Chairman, D.C. Board of Parole.....	23, 257
Prepared statement.....	26
Mack, Gladys, Director, Office of Policy and Program Evaluation, Executive Office of the Mayor, District of Columbia.....	67
Prepared statement.....	68
Mahoney, John D., Budget Officer, Public Health Service, Department of Health and Human Services.....	47
Martin, Clarence, executive director, Association for the Advancement of Psychology.....	108
Prepared statement.....	195
Mayer, Dr. William E., Administrator, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health and Human Services.....	47
Prepared statement.....	49
Moultrie, Hon. H. Carl, Chief Judge, Superior Court of the District of Columbia.....	299
Prepared statement.....	314
Palmer, James, Director, Department of Corrections, District of Columbia.....	1, 331
Prepared statements.....	4, 333
Peeples, Louis, administrator, Council 20, AFSCME, letter from.....	214

	Page
Perrotta, Ralph, president, Superior Court Trial Lawyers Association	224
Pittman, James, Executive Officer, National Institute of Mental Health, Department of Health and Human Services	47
Polansky, Larry, Executive Officer of the District of Columbia Courts	299
Reveal, Betsy, Director, Office of the Budget, District of Columbia	219, 324, 331
Prepared statement	324
Rosenberg, Norman, director, Mental Health Law Project	108
Prepared statement	192
Rosenthal, Douglas Eurico, Esq., counsel, Superior Court Trial Lawyers Association	224
Ross, Edward D., Jr., Assistant U.S. Attorney and Director, superior court operations	23, 257
Secundy, Lillian, president, Mental Health Association of the District of Columbia	77
Prepared statement	80
Simmons, Dr. Juliette, past president, Mental Health Association of the District of Columbia	77
Simms, Sgt. Richard, victim of violent crime	257
Prepared statement	275
Simon, Dr. Gottlieb, board member, Mental Health Association of the District of Columbia	77
Solomon, Larry, Acting Director, National Institute of Corrections, Department of Justice	331
Specter, Hon. Arlen, U.S. Senator from Pennsylvania, prepared statements	3, 258
Thornton, Juanita, Chairperson, District of Columbia Commission on Aging, prepared statement	216
Tobelman, Dr. Barbara I., executive director, Mental Health Association of the District of Columbia	77
Valentine, Patricia, victim of violent crime	257
Prepared statement	279
Whitfield, Salanda, Acting Assistant Director for Correctional Services, Department of Corrections, District of Columbia	1
Williams, Hallem, consultant to D.C. Board of Parole	257
Wilson, Shirley, D.C. Office of Criminal Justice Plans and Analysis	257
Zielinski, Michael E., Assistant Corporation Counsel, District of Columbia	1

SUBJECT INDEX

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

	Page
Drug abusers, treatment for	60
Nursing homes, availability of	61
St. Elizabeths Hospital:	
Future of	55
Need for staff cuts and program reductions	59
Objectives for	57
Reduction in force of 653 people	63
Setting up a corporation	64
Shifting responsibility for care of patients	62
Transfer of fiscal and management responsibilities	58

DISTRICT OF COLUMBIA

BOARD OF PAROLE

Career Criminal Act	45
Case findings	270
Case of:	
Melvin Wynn	272
Nathaniel Washington	276
Norman Coleman	272
Caseload	25
Community, safety of the	291
Conviction rate, evaluation of	32
Criminals, premature release of	290
D.C. Prison complex, capacity of	38
Dangerous prisoners, early parole of	39
Incarceration, periods of	260
Iowa risk assessment	287
Juvenile records, use of	42
Law enforcement agencies:	
Notifying other	292
Recommendations from	33
Melvin Wynn, record of	280
Members:	
Background of	28
Listing	27
Terms and compensation of	27
180-day court rule	43
Overall evaluation of Board	38
Overcrowding, granting parole to relieve	31
Parole Board:	
Changing practices of	287
Judgment as to releases	282
Power of	25
Suggestions for	39
Parole:	
Criteria for granting	28, 30

Parole (Continued)	Page
Recommendations for.....	40
Revocation of.....	37
Parolees, recidivism of.....	30
Persons rearrested, statistics of.....	297
Prison inmate population.....	259
Processing persons for parole, backlog in.....	34
Rand Corp.'s survey of California inmates.....	281
Rate of release, appropriate.....	293
Recidivism study.....	286
Recommendations from institutions.....	29
Resources, need for additional.....	35
Study, completion of.....	287
Testimony of:	
Patricia Valentine.....	277
Sergeant Simms.....	272
U.S. attorneys provided in last year's budget.....	42
Waiver age of juveniles to adults.....	41
Youth, release of.....	288
DEPARTMENT OF CORRECTIONS	
Appropriated funds, outlining use of.....	338
Classified information in file cabinets.....	356
New policy for inspecting incoming furniture.....	357
Correctional system, purpose of the.....	348
Criminal justice coordinator, full-time.....	351
Criminal justice problems, piecemealing.....	15
D.C. Jail:	
Capacity at.....	9
Relieving overcrowding at.....	7
District officials, good job of.....	2
Education services:	
Achieving functional competency.....	343
Allocation of \$22.3 million.....	338
Current proposal for use of funds.....	339
Identification of inmates for program.....	341
Including females in program.....	341
Involvement of National Institute of Corrections.....	353
Length of time to train an illiterate.....	342
National level of functional competency.....	345
Number of inmates needing.....	338
Plan to implement program.....	352
Putting educational program in place.....	352
Use of computers.....	346
Inmate population, ideas for reducing.....	11
Institution services, makeup of.....	340
Jail and prison programs, overcrowding of.....	350
Jobs program, money for.....	8
Lorton:	
Current capacity of.....	12
Moving prisoners from detention center to.....	6
Shakedown at.....	358
Visits to.....	2
Mayor's Coordinating Council.....	352
Parole Board members, authority to recall former.....	14
Parole officers:	
Cost of additional.....	17
Need additional.....	17
Supervision of.....	17
Parole system, evaluation of.....	17

Parolees:	Page
Current number of	18
Funds needed for processing	14
Resources needed to increase process	16
Time for processing	14
Paroling 128 inmates	7
Physical facilities, expansion of	11
Pretrial detention:	
Double celling	9
Impact of seven additional judges on	16
Raid, inadequate coordination of recent	6
Raising bail, analysis of	12
Senator Specter, praising the visit of	5
St. Elizabeths, available space at	10

EXECUTIVE OFFICE OF THE MAYOR

St. Elizabeths Hospital:	
Analysis of programs proposed to be cut	75
Comprehensive plan for	73
Definition of a District resident	74
National program objectives for	74
Overall view of proposed proposal of Federal Government	75

OFFICE OF THE BUDGET

Authorization of additional judgeships, noncommittal on	325
Cases requiring legal services, types of	223
Criminal Justice Act program, overview of	220
Fee structure, establishing the	222
Outside lawyers, payment to	222
Preparation time versus trial time	221

PUBLIC DEFENDER SERVICE

Billable hours, use of	249
Criminal Justice Act lawyers, salary cap of	249
Defendants on trial charged with new violent crimes	326
Lawyers:	
Number and salary of	247
Number of PDS lawyers earning in excess of \$40,000	249
Office, location of	247
Overhead cost, estimation of	248
Pretrial services, services of	328
Secretaries, number of	248
<i>Whitefield Graves v. United States</i> , case of	328

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

Arrest to indictment, average time from	302
Cases awaiting disposition, number of	305
Felony cases:	
Backlog of	301
Number of on bail and in custody	302
Horsky report, calendar days in	305
Individual judge calendars	304, 313
Other jurisdictions with	312
Judges:	
Assignment of	304, 310
Assistance in getting seven	312
Distribution of 44	304
Status of seven new	308
Use of more on criminal cases	309

Misdemeanor cases:	Page
Improvement in backlog of	303
Number in jail and number on bond	305
Pretrial release, rearrest of persons on	306
Serious arrest cases, media focus on	311

NONDEPARTMENTAL WITNESSES

St. Elizabeths Hospital:	
Alternative facilities grossly inadequate	200
Community hearing on OMB's proposal to close or curtail services at St. Elizabeths Hospital	80
Court-ordered continuum of services	108
Effects of cutbacks	77
Panel reports	109
Programs marked for elimination	199
Results of cuts of the hospital budget	192
Compensation for lawyers in criminal cases:	
Antitrust issue, no legitimate	246
Bill, advantages and disadvantages of	230
Billable hours, number of	229
Categories of payments, two	226
Charge for comparable services in private practice	226
Compensation levels by State	242
Public defenders, cost of full-time	245
Investigators	231
Rates charged by	242
Negotiations for settlement arrangements	226
Overhead:	
Average for practicing lawyers	227
For fully staffed law firm	252
Paralegal charges	252
People affected, number of	244
Price-fixing, issue of	243
Service provided, quality of	229
Shortage of lawyers threatened	243